



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Washington**

**Application for 2010  
Annual Report for 2008**



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# Table of Contents

|  |     |
|--|-----|
| I. General Requirements .....                            | 4   |
| A. Letter of Transmittal.....                            | 4   |
| B. Face Sheet .....                                      | 4   |
| C. Assurances and Certifications.....                    | 4   |
| D. Table of Contents .....                               | 4   |
| E. Public Input.....                                     | 4   |
| II. Needs Assessment.....                                | 6   |
| C. Needs Assessment Summary .....                        | 6   |
| III. State Overview .....                                | 9   |
| A. Overview.....   | 9   |
| B. Agency Capacity.....                                  | 14  |
| C. Organizational Structure.....                         | 17  |
| D. Other MCH Capacity .....                              | 17  |
| E. State Agency Coordination.....                        | 19  |
| F. Health Systems Capacity Indicators .....              | 27  |
| Health Systems Capacity Indicator 01: .....              | 28  |
| Health Systems Capacity Indicator 02: .....              | 29  |
| Health Systems Capacity Indicator 03: .....              | 31  |
| Health Systems Capacity Indicator 04: .....              | 32  |
| Health Systems Capacity Indicator 07A: .....             | 34  |
| Health Systems Capacity Indicator 07B: .....             | 36  |
| Health Systems Capacity Indicator 08: .....              | 38  |
| Health Systems Capacity Indicator 05A: .....             | 39  |
| Health Systems Capacity Indicator 05B: .....             | 40  |
| Health Systems Capacity Indicator 05C: .....             | 41  |
| Health Systems Capacity Indicator 05D: .....             | 43  |
| Health Systems Capacity Indicator 06A: .....             | 45  |
| Health Systems Capacity Indicator 06B: .....             | 45  |
| Health Systems Capacity Indicator 06C: .....             | 46  |
| Health Systems Capacity Indicator 09A: .....             | 47  |
| Health Systems Capacity Indicator 09B: .....             | 48  |
| IV. Priorities, Performance and Program Activities ..... | 49  |
| A. Background and Overview .....                         | 49  |
| B. State Priorities .....                                | 50  |
| C. National Performance Measures.....                    | 51  |
| Performance Measure 01: .....                            | 51  |
| Performance Measure 02: .....                            | 55  |
| Performance Measure 03: .....                            | 58  |
| Performance Measure 04: .....                            | 62  |
| Performance Measure 05: .....                            | 65  |
| Performance Measure 06: .....                            | 68  |
| Performance Measure 07: .....                            | 71  |
| Performance Measure 08: .....                            | 75  |
| Performance Measure 09: .....                            | 77  |
| Performance Measure 10: .....                            | 80  |
| Performance Measure 11: .....                            | 83  |
| Performance Measure 12: .....                            | 86  |
| Performance Measure 13: .....                            | 90  |
| Performance Measure 14: .....                            | 93  |
| Performance Measure 15: .....                            | 95  |
| Performance Measure 16: .....                            | 98  |
| Performance Measure 17: .....                            | 101 |
| Performance Measure 18: .....                            | 103 |

|   |     |
|---|-----|
| D. State Performance Measures.....                                      | 107 |
| State Performance Measure 1: .....                                      | 107 |
| State Performance Measure 5: .....                                      | 110 |
| State Performance Measure 6: .....                                      | 113 |
| State Performance Measure 7: .....                                      | 116 |
| State Performance Measure 8: .....                                      | 120 |
| State Performance Measure 9: .....                                      | 122 |
| State Performance Measure 10: .....                                     | 125 |
| E. Health Status Indicators .....                                       | 128 |
| Health Status Indicators 01A:.....                                      | 128 |
| Health Status Indicators 01B:.....                                      | 129 |
| Health Status Indicators 02A:.....                                      | 130 |
| Health Status Indicators 02B:.....                                      | 131 |
| Health Status Indicators 03A:.....                                      | 131 |
| Health Status Indicators 03B:.....                                      | 132 |
| Health Status Indicators 03C:.....                                      | 133 |
| Health Status Indicators 04A:.....                                      | 134 |
| Health Status Indicators 04B:.....                                      | 134 |
| Health Status Indicators 04C:.....                                      | 135 |
| Health Status Indicators 05A:.....                                      | 136 |
| Health Status Indicators 05B:.....                                      | 137 |
| Health Status Indicators 06A:.....                                      | 137 |
| Health Status Indicators 06B:.....                                      | 138 |
| Health Status Indicators 07A:.....                                      | 138 |
| Health Status Indicators 07B:.....                                      | 139 |
| Health Status Indicators 08A:.....                                      | 139 |
| Health Status Indicators 08B:.....                                      | 140 |
| Health Status Indicators 09A:.....                                      | 140 |
| Health Status Indicators 09B:.....                                      | 141 |
| Health Status Indicators 10: .....                                      | 142 |
| Health Status Indicators 11: .....                                      | 142 |
| Health Status Indicators 12: .....                                      | 142 |
| F. Other Program Activities.....  | 143 |
| G. Technical Assistance .....   | 146 |
| V. Budget Narrative .....   | 151 |
| A. Expenditures.....  | 151 |
| B. Budget .....   | 153 |
| VI. Reporting Forms-General Information .....                           | 158 |
| VII. Performance and Outcome Measure Detail Sheets .....                | 158 |
| VIII. Glossary .....  | 158 |
| IX. Technical Note .....  | 158 |
| X. Appendices and State Supporting documents.....                       | 158 |
| A. Needs Assessment.....  | 158 |
| B. All Reporting Forms.....   | 158 |
| C. Organizational Charts and All Other State Supporting Documents ..... | 158 |
| D. Annual Report Data .....   | 158 |

## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section.***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

To obtain a copy of the Assurances and Certifications, contact:

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### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

### **E. Public Input**

Input for the MCH Block Grant application involved multiple stakeholder groups, including families and family organizations. These groups are actively engaged with specific MCH sections and one or more MCH population group. They represent communities, healthcare professionals, universities, state agencies, local health jurisdictions, and other organizations. They are knowledgeable and articulate about MCH needs and emerging issues.

Involving stakeholders in our MCH Block Grant Application and Five Year Needs Assessment Process allows for greater appreciation and understanding of work at all levels and mutual learning, problem solving, and growth. Stakeholders provided input throughout development of our Five Year Needs Assessment. Progress was shared regularly as the OMCH Director, managers, and staff met with stakeholders. Presentations were made to multiple groups as we began to frame the assessment and identify potential MCH priorities. Feedback from presentations was overwhelmingly positive. The framework and language in the draft priorities resonated with all groups and they commented about how beneficial it would be for them and for state level work.

Stakeholders continue to be included in shaping the final MCH priorities through the existing communication channels, workgroups, etc. In this way, the priorities and related performance measures continue to be relevant for all of Washington State.

/2007/OMCH made sections of the block grant available for public comment on DOH's website. The complete application will be available on the same website later this year.//2007//

/2008/Public input was requested as in 2007. We sent an announcement about the opportunity to review and comment on this year's application via email to over 360 parents, partners, and colleagues. A 10-day review period resulted in 3 comments. 2 of them were very positive and complementary regarding the planned activities/programs. One was a suggestion about how to better represent the role of service providers for CSHCN and collect and use data regarding CSHCN. The entire application and annual report will be available on OMCH's website after final submission to HRSA in September 2007.

The Children With Special Health Care Needs section (CSHCN) conducted 2 focus groups of parents of children with special health care needs. Discussions focused on the activities described in the performance measures, history of the block grant, and federal expectations for states.//2008//

/2009/In addition to the ongoing public input we solicit, we posted the 2009 application to our website. We received 5 comments, all positive. 2 encouraged continued support of family organizations. One suggested addressing rising transportation costs and their impact on access to care. The entire application/annual report will be available on OMCH's website after submission to HRSA in September 2008.

CSHCN recruited a group of emerging family leaders with children with special needs to learn the history of the block grant and review proposed CSHCN activities. They were invited to continue working with the section to revise the process of determining activities to support performance measures for CSHCN. Meetings with this group will continue.//2009//

***/2010/In addition to the ongoing public input we solicit, the 2010 application was posted to our website. The entire application/annual report will be available on OMCH's website after submission to HRSA in September 2008.***

***CSHCN had a group of family leaders with children with special needs review proposed CSHCN activities and the block grant. They work with the section on an ongoing basis and their input informs CSHCN activities. CSHCN also shared the block grant materials with their Communication Network partners who consist of their contractors, staff from other state agencies, local health jurisdiction CSHCN staff, consumer groups, and other stakeholders who meet quarterly.***

***The Child and Adolescent Health section (CAH) routinely gathers input from youth regarding teen pregnancy prevention efforts. This is done through focus groups (generally a statewide series of both adult and youth focus groups) aimed at gathering input on a specific topic, such as developing media literacy curricula or a media campaigns.***

***OMCH gathers public input into its programs on a continuing basis through a variety of methods. We use focus groups to gather information to develop new program activities. Several sections have advisory groups consisting of both public and private providers and parent and public members. Examples of ongoing stakeholder avenues for input include CHILD Profile Advisory Group, CSHCN Communications Network, Combating Autism Advisory Committee, Parent to Parent, Fathers Network, Perinatal Advisory Committee, Vaccine Advisory Committee, and various learning collaboratives.//2010//***

## II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

Process, Partnerships, and Identifying Priorities

In 2004 and 2005, the Washington State Department of Health (DOH) Office of Maternal and Child Health (OMCH) undertook a comprehensive strategic planning approach to identify priorities for addressing the needs of the maternal and child population. We worked with internal partners within DOH and external partners throughout the state. External partners included local public health staff and Public Health Nursing Directors, the Perinatal Advisory Committee, University of Washington (UW) School of Nursing, Department of Social and Health Services, Children with Special Health Care Needs Communication Network, regional perinatal programs, March of Dimes, Healthy Mothers Healthy Babies (now known as WithinReach), Children's Hospital and Regional Medical Center (CHRM), and the Genetics Advisory Committee.

*//2010/CHRM is now called Seattle Children's.//2010//*

The 2005 Needs Assessment (NA) was developed based on the following principles adopted by the OMCH Management Team:

- 1) Commitment by the management team to lead the NA,
- 2) Focus on promoting health and wellness,
- 3) Commitment to incorporate the NA into system-wide strategic planning for OMCH,
- 4) Integration of work activities across all OMCH sections,
- 5) Involvement of staff in integrated workgroups, and
- 6) Use of existing stakeholder groups to gather input, review process, and validate results.

The resulting 2005 NA involved a three-step process:

- 1) Identifying the needs of the population,
- 2) Assessing the capacity within the state to meet those needs, and
- 3) Prioritizing the needs through work with stakeholder groups.

Subsequent development of the priorities included working with stakeholders to refine the scope and purpose of each priority. By the end of 2006, OMCH and its partners had selected nine priority outcomes for maternal and child health in Washington State:

- 1) Adequate nutrition and physical activity
- 2) Lifestyles free of substance use and addiction
- 3) Optimal mental health and healthy relationships
- 4) Health Equity
- 5) Safe and healthy communities
- 6) Healthy physical growth and cognitive development
- 7) Sexually responsible and healthy adolescents and women
- 8) Access to preventive and treatment services
- 9) Quality screening, identification, intervention, and care coordination

Using the Priorities and Continued Assessment of Capacity and Needs

Washington's MCH priority outcomes are supported by many activities. In 2007 and 2008 we used

the priorities to guide difficult budget decisions in the face of substantial federal cuts to the block grant. We also adapted activities for efficacy and sustainability. Each priority is described and connected to state and national public health agendas in an issue brief. OMCH updates the MCH Priority Issue Briefs annually to reflect changes in activities and data related to each priority. Issue briefs updated in June 2008 can be viewed as an attachment to Section IIC of the 2008 block grant application. The following are a few examples of how MCH priority outcomes are used by OMCH and its agency and local partners.

***/2010/Current Issue Briefs are attached./2010//***

1) OMCH used the priorities to frame discussions and presentations within the agency and with external partners. For example, Priority Three: Optimal Mental Health and Healthy Relationships provided the framework for a presentation to Master's in Public Health (MPH) students in UW's Maternal and Child Health program.

2) Priority Five: Safe and Healthy Communities was used by the DOH Injury Prevention program to identify activities supported by OMCH for a grant application.

3) The OMCH management team relied on the priorities to guide them through difficult budget decisions in the face of block grant reductions.

4) A workgroup of local public health representatives and OMCH program representatives used the MCH priority outcomes to help make decisions about changes to the funding formula for the distribution of block grant funds to local public health jurisdictions.

5) The Community and Family Health Division within DOH used the MCH priority outcomes to help shape the division's strategic planning process called Mission, Values, and Priorities.

6) The Child and Adolescent Health section within OMCH used the MCH priorities in its strategic planning process.

7) MCH Combined Teams regularly share the MCH priority outcomes with local public health partners and seek input from them about the MCH priorities.

8) Authors used the MCH priorities to frame the introduction to the Maternal and Child Health chapter in the 2007 Health of Washington State report, a comprehensive data report on multiple health indicators.

/2009/In April 2008, the OMCH Health Disparities Workgroup completed the issue brief for Priority Four: Health Equity, through collaborating with the OMCH management team. In May 2007, the two groups held a retreat to discuss health disparities work in OMCH. Each section in the office contributed to the content of the issue brief by helping draft the focus statement, expectations, and objectives. Each section also identified key data and notable activities for inclusion in the document.

The 2005-09 MCH priorities and the issue briefs developed for them were used in 2007-08 to guide the development of three new state performance measures. The new measures will replace three retired measures. These new measures are currently process measures. Over time, OMCH will transition these process measures into outcome measures. The 2005-09 MCH priority goals will continue to influence the development and results of Washington's state performance measures.

OMCH has attempted to integrate ongoing NA planning and evaluation into our work. To facilitate this OMCH recently provided two program evaluation trainings to all OMCH staff. The first session was an introduction to program evaluation, based on the CDC Framework for Program Evaluation. The second session discussed advanced evaluation techniques, question

development, data collection, development of an analytic plan, and interpretation of results.//2009//

More detailed descriptions of the 2005 Needs Assessment methodology and results are available in Washington's 2006 and 2007 Maternal and Child Health Block Grant applications.

***/2010/In January 2009, MCH Assessment (MCHA) updated several chapters of the MCH Data Report. MCHA will continue to update chapters of this report on a rotating basis. Two new chapters will be added by September 2009.***

***In May 2009, MCHA updated the Perinatal Indicator Report, which includes health indicators on pregnant women and newborn infants. The report was first published in 2004 in response to a request from the Perinatal Advisory Committee. MCHA also published the Youth with Disabilities: Risk Factors for Tobacco, Alcohol and Drug Use report and Primary Care Providers' Perspectives on Serving Young Adults with Special Health Care Needs report. As part of the 2010 needs assessment, MCHA will update the Adolescent Needs Assessment Report by September 2009. MCHA continues to collect and publish data from Pregnancy Risk Assessment Monitoring System (PRAMS) and coordinate the implementation and analysis of the Healthy Youth Survey.//2010// An attachment is included in this section.***

### III. State Overview

#### A. Overview

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Columbia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. A mild, humid climate predominates in the western part of the state. The climate is cooler and drier east of the Cascade Range.

Population Density (See attached map)

In 2008, the average population density in Washington was 99.0 persons per square mile. The national rate from the 2000 Census was reported at 79.6 persons per square mile.<sup>(1)</sup> Nearly 80% of Washington's population is concentrated west of the Cascades. The three most populous counties, King, Pierce, and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon. The city of Spokane and Spokane County in Eastern Washington are near enough to benefit from Coeur d'Alene, Idaho.

Geography, climate, and economic resources influence Washington's population distribution. Population density ranges from 886 persons per square mile in King County to 3 persons per square mile in Garfield and Ferry counties.<sup>(2)</sup> Washington has 39 counties, each with its own local government. These counties form 35 independent local health jurisdictions (LHJs), funded with varying amounts of federal, state, and local dollars.

#### Economy

Washington State continues to struggle with an economic slowdown resulting from a combination of factors. The burst dot.com bubble and the decline of airplane demand after September 11, 2001 significantly affected Washington's technical and industrial economic base. In addition, the first case of bovine spongiform encephalopathy (BSE or mad cow disease) was found in Mabton, Washington in November 2003. This resulted in economic challenges for Washington's beef farmers and agriculture industry. In November 2003, the State's seasonally adjusted unemployment rate was 7.2%. Washington's unemployment rate remains one of the highest in the nation, ranked as 38th. The state's unemployment rate was 5.5% (as of April 2005) compared to 5.4% nationally (February 2005).<sup>(3)</sup>

/2007/Washington State's economy remains slow after the 2001 downturn. In March 2006, Washington's unemployment rate was 4.6%, which is comparable to the national unemployment rate of 4.7% (April 2006). Washington is ranked 30th among all the states for unemployment.<sup>(3)</sup>//2007//

/2008/In March 2007, the State's seasonally adjusted unemployment rate was 4.6%. Washington's unemployment rate remains one of the highest in the nation, ranked as 38th.<sup>(3)</sup>//2008//

/2009/The state faces the same challenges as many other states throughout the country with respect to budget deficits, rising unemployment, a declining real estate market, housing foreclosures, and rising fuel prices. The most recent revenue forecast from June 2008 projects a state General Fund decrease of 50 million for the coming state fiscal year and 118 million for the next state biennium. (<http://www.ofm.wa.gov/news/release/2008/080619.asp>) In addition, the seasonally adjusted unemployment rate in Washington rose to 5.3%, the first time in 20 months it has risen above 5% (<http://www.esd.wa.gov/newsandinformation/releases/may-unemploymentstats-08-034.php>)//2009//

***/2010/In March 2009, Washington State's seasonally adjusted unemployment rate was 9.2% and there was no significant job growth in any major industry or sector. (<http://www.esd.wa.gov/newsandinformation/releases/unemployment-rate-grew-in-march.php>). A \$ 2.1 Billion reduction in state revenue is forecast for the 2009-2011 biennium. (<http://ofm.wa.gov/budget/>).(4)//2010//***

Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. The legislature adopted a budget that decreased expenditures to meet a \$XX shortfall. In order to meet the anticipated shortfalls, Washington State has been under a number of freeze directives from both the Governor and the Legislature. The various freezes have impacted hiring, contracts, equipment purchases and travel. The first freeze was enacted in August 2008 and continues through August 2009. The impact on the Department of Health's budget is noted in Section V.A and V.B.

In the past, state revenue surpluses have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the state's capacity to subsidize local government revenue shortfalls, with the result that many local programs are struggling financially. At the same time, economic hard times have increased the need for public health services at the local level, so the current decrease in funding is having a major impact on local public health. As the economic and state fiscal crisis continues, future reductions in local public health are expected. LHJs are currently being forced to reduce staff and programs.

*/2007/Federal funding cuts and state general fund shortfalls continue, making it necessary to further reduce funding to state and local public health programs.//2007//*

*/2008/The Washington State Legislature passed legislation in 2007 to support additional funding for local public health. The legislation requires local public health departments to use funds provided by the legislature to address core public health functions. "Health services that promote healthy families and the development of children," is one of six activities listed in the definition of core public health functions of statewide significance. The amount of funds received by local public health will depend on the funding provided by the Legislature in each budget cycle; this amount can fluctuate. In 2007-09, approximately \$20 million will be distributed among the 35 local public health agencies in Washington.//2008//*

## Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,121, an increase of 21.1% since the 1990 Census.(1) The Washington State Office of Financial Management's (OFM) preliminary intercensal population estimate for the state in 2004 was 6,167,800.(2)

*/2007/The population of Washington State more than doubled between 1960 and 2005. 50 to 75% of the growth is the result of net migration and the rest is from natural increase. OFM's preliminary intercensal population estimate for 2005 was 6,256,400.(2)//2007//*

*/2008/OFM's intercensal population estimate for 2006 was 6,375,600.(2)//2008//*

*/2009/OFM's intercensal population estimate for 2007 was 6,488,000.(2)//2009//*

***/2010/OFM's intercensal population estimate for 2008 was 6,587,600.(2)//2010//***

According to the 2000 Census, Washington ranked seventh in the country in numerical population growth and tenth in percent age population growth since 1990.(1) However, from 1995-2000 growth slowed to an average of 1.3% per year and since 2000, has averaged 1.1% per year. Since 1995, natural population increase (births minus deaths) has remained fairly constant, while

net migration (people moving into the state versus people moving out) has decreased from 68,300 in 1995 to an estimated 23,100 in 2003.(2)

/2007/OFM is projecting a significant increase in the number of people migrating to Washington in the coming years.(2)//2007//

/2008/In the past ten years, the state population has increased approximately 12%.(2)//2008//

/2009/Net migration (people moving into the state versus people moving out) increased from 34,600 in 2004 to 70,455 in 2007.(2)//2009//

**/2010/Net migration has slowed to 58,897 in 2008/2010/(2)**

#### Race/Ethnicity in Washington State

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8% of Washington's population reported its race as White, 5.5% Asian, 3.2% Black, 1.6% American Indian or Alaskan Native, 0.4% Native Hawaiian and other Pacific Islander, and 3.9% Other. Individuals who reported two or more races accounted for 3.6%. Finally, 7.5% of the population reported Hispanic or Latino ethnicity.(9) Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Together, non- Whites and Hispanics in Washington increased from 13.2% of the overall population in 1990 to 21% (1,241,631) of the population in 2000. The state population of Asian/Pacific Islanders increased by 78%; Blacks by 35%; and American Indians, Alaska Natives, and Aleuts by 29%.(1)

/2009/The most recent population estimates produced by OFM in 2006 predict a general increasing trend among the population of non- White and Hispanic residents.(2)//2009//

The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. Counties with large proportions of Hispanics tend to be located in rural areas of Eastern and Central Washington. In Adams County, the Hispanic population rose from 32.8% in 1990 to 47.1% in 2000; Franklin County saw an increase from 30.2% to 46.7%; and Yakima County saw an increase from 23.9% to 35.9%. While Hispanics make up a large proportion of the population in these counties, most Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7%) of Hispanics in Washington are from Mexico, 20.6% are from other countries (Central and South America), 3.7% from Puerto Rico, and 1.0% from Cuba.(1) In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, most of whom were Hispanic. Migrant and seasonal farm workers are more likely to face language barriers, and to have low family incomes and limited transportation options. Most rely on Community and Migrant Health Centers (CMHC) for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 50% of each population resides in King County alone. There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas. Two additional tribes are seeking federal recognition.

#### Languages

According to the 2000 Census, approximately 15%, or 168,000, of Washington's children age 5-17 years speak a language other than English at home. Of these children, 43% speak Spanish, 29% speak Asian and Pacific Islander languages, 26% speak other Indo-European languages, and 4% speak other languages. A similar figure of 14%, or 512,000, of the adult population age 18-64 years does not speak English at home. Of those who do not speak English at home, 88% of the children and 75% of the adults speak English "very well" or "well." 12% of the children and

25% of the adults, speak English "not well" or "not at all."(1) Approximately 40,700 Spanish-speaking students were enrolled in the English as a Second Language program in Washington State for the 1999-2000 school year. Other languages with high enrollments were Russian (5,500), Vietnamese (3,200), Ukrainian (2,900), Korean (1,800), Cambodian (1,400), and Tagalog (1,000).(1)

## Age

In 2003, there were 80,482 resident births in Washington State. The 2000 Census population counts show that almost 22%, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (age 15-44 years). Nearly 29%, or 1.68 million, were children age 19 years and younger. There were over 125,000 women ages 15 to 17 years. Adolescent pregnancy rates (age 15-17 years) declined in Washington from 57.9 per 1,000 women in 1990 to 28.8 per 1,000 women in 2003. A State forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially.(5)

The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase. In 2004, there were an estimated 1,120,913 children and adolescents aged 5 to 17 years.(6)

/2007/In 2004 there were 81,715 resident births in Washington State.(5)//2007//

/2008/In 2005, there were 82,625 resident births in Washington State. Adolescent pregnancy rates (age 15-17 years) declined in Washington from 57.9 per 1,000 women in 1990 to 27.6 per 1,000 women in 2005.(5)

In 2007, there were an estimated 1,148,084 children and adolescents aged 5 to 17 years.(6)//2008//

/2009/In 2006, there were 86,485 births in Washington State. Birth and pregnancy rates among women 15-24 years declined substantially from 1990-2003, but no clear pattern has emerged recently.(5)

In 2006, there were an estimated 1,137,975 children and adolescents aged 5 to 17 years in Washington.(6)//2009//

**/2010/In 2007, there were 88,921 births in Washington State.(5)**

**In 2008, there were an estimated 1,154,962 children and adolescents aged 5 to 17 years in Washington.(6)//2010//**

## Urban/Rural

72% of population growth over the past decade occurred in the western portion of the state, where the majority of the population lives. While there are many rural areas in Western Washington, the most rural counties are located in Eastern Washington. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates. A recent review of health status indicators found some differences between the health status of rural and urban residents, though it is difficult to assess specifically whether the decreased health status is linked to rural location, isolation, or decreased access to care.(7)

## Poverty and Health Insurance

According to the 2004 Washington State Population Survey, an estimated 24.5% of Washington households had a family income below 200% of the Federal Poverty Level (FPL), compared to

18.8% in 2002. An estimated 9.9% of households had an income below the 100% FPL. Data on households with children is not yet available, but according to the 2002 Washington State Population Survey, an estimated 35% (approximately 574,000) of children in Washington were living below 200% FPL (FPL = \$18,392 for a family of four in 2002), compared to 33.4% in 2000. An estimated 18% (about 284,000) of the children were living below 100% FPL and 11% (about 180,000) were living at or below 50% FPL.(6)

/2007/According to the 2004 Washington State Population Survey, an estimated 38% (approximately 640,985) of children in Washington were living below 200% FPL. An estimated 19% (about 322,188) of the children were living below 100% FPL and 10% (about 169,573) were living at or below 50% FPL.(6)//2007//

/2008/According to the 2004 Washington State Population Survey, an estimated 22.1% of Washington households had a family income below 200% of the Federal Poverty Level (FPL), compared to 24.5% in 2004, and 18.8% in 2002. An estimated 8.0% of households had an income below 100% FPL.(6)//2008//

Findings from the 2004 Washington State Population Survey indicate the percent of Washington residents without health insurance is also increasing. Among the general population, 8.4% were uninsured in 2002 compared to 9.8% in 2004, a 17% increase. The percent of uninsured children increased approximately by 33% from 4.5% in 2002 to 6.0% in 2004, equaling over 98,000 uninsured children in Washington.(6)

/2008/Findings from the 2006 Washington State Population Survey indicate the percent of Washington residents without health insurance has decreased in the past two years, although this change is not significant. Among the general population, 9.3% were uninsured in 2006, compared to 9.9% in 2004, compared to 8.4% in 2002, showing an overall increase of 11%. The percent of uninsured children decreased from 5.9% in 2004 to 4.4% in 2006, this was not a statistically significant change.(6)//2008//

***/2010/The 2007 Washington State Population Survey indicates that the percent of Washington residents without health insurance has risen in the past two years. Among the general population, 11% were uninsured in 2008, compared to 9.3% in 2006. This increase, however, is not statistically significant. The percent of uninsured children increased from 4.4% in 2006 to 4.8% in 2008; however, this is also not a statistically significant change.//2010//***

The Washington State Medical Assistance Administration (MAA) funds health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2003, Medicaid covered pregnant women up to 185% FPL and paid for prenatal care and deliveries for approximately 46% of state births.(8) The Take Charge program at MAA provides family planning for men and women with incomes at or below 200% FPL. The State Children's Health Insurance Program (SCHIP) provides health coverage for children of families with incomes between 200% and 250% FPL.

/2007/The Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) recently changed its name to DSHS Health and Recovery Services Administration (DSHS-HRSA).//2007//

/2008/The Washington State Legislature passed legislation in 2007 to expand eligibility for state subsidized health insurance to children in families with incomes up to 250% FPL. The income limit goes up to 300% FPL in 2009. In addition, families with incomes above 300% FPL will be able to purchase Medicaid coverage by paying the full cost. The legislation also provides incentives to primary care providers to become medical homes for children and families.//2008//

(1) US Census Bureau, Census 2000

(2) Washington State Office of Financial Management, Population, <http://www.ofm.wa.gov/pop/default.asp>

(3) US Department of Labor, Bureau of Labor Statistics, March 2008.

(4) Washington State Economic and Revenue Forecast Council, <http://www.erfc.wa.gov/.asp>

(5) Washington State, Pregnancy and Induced Abortion Statistics 2006, Center for Health Statistics, April 2008.

(6) Washington State Office of Financial Management, Research and Data, State Population Survey. <http://www.ofm.wa.gov/sps/default.asp>.

(7) Schueler V, Stuart B. "Recent research and data on rural health in Washington State," Olympia, Washington, October 2000.

(8) Cawthon, Laurie. "Characteristics of Washington State Medicaid Women Who Gave Birth," DSHS Research and Data Analysis, 2/23/2005.

***An attachment is included in this section.***

## **B. Agency Capacity**

The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. OMCH programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. Maternal and child health (MCH) data are collected, analyzed, and shared with other agencies and organizations to help ensure sound decision-making around health care policies and practices. OMCH program activities emphasize infrastructure-building and population-based activities through preventive health information and educational messages to the public and to health care providers about early identification of health issues, referral and linkage to services, and coordination of services.

OMCH is responsible for administering the Title V Block Grant, the Centers for Disease Control and Prevention (CDC) Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures. OMCH contracts with 35 local health jurisdictions (LHJs) and several community-based organizations, universities and hospitals, direct service providers, family organizations, and others to address MCH priorities and state and national performance measures.

State statutes relevant to the Title V program authority and how they affect the Title V program remain the same as those outlined in pages 8-11 of the 1996 Block Grant Application. Capacity for better understanding of cultural competence as an office and for staff has improved over the years due to continued participation in the division level Multicultural Workgroup and ongoing training.

OMCH addresses health disparities through program activities driven by data demonstrating a need for targeted efforts to reduce or eliminate disparities. We also established the OMCH Health Disparities Workgroup. This group was created several years ago to help sections within the office work together to address health disparities in the MCH population. The OMCH Health Disparities Workgroup and the OMCH Management Team recently worked together to develop MCH Priority 4, Health Equity. The groups met in May 2007 to identify program activities addressing health disparities and suggest ideas for the role and scope of the OMCH Health Disparities Workgroup. Future work will emphasize using data to focus activities and drive decision making. In addition, the Community and Family Health Division established a division wide health disparities workgroup. Representatives from OMCH serve on this workgroup. The

first task of the division workgroup is to survey all the programs in the division for information about activities that aim to address health disparities. Statewide, the Legislature passed legislation creating the Governor's Interagency Council on Health Disparities. The Department of Health is represented on the council. By 2010 the council must develop a plan to reduce health disparities for certain outcomes in specific populations. Several of the outcomes are related to maternal and child health.

Each of the six specialized sections within OMCH have the capacity to support programs to help create infrastructure and provide population based services, enabling services, and limited direct services to the maternal and child health population. Each section has a specific focus. Three sections focus on the major Title V populations: Maternal and Infant Health, Child and Adolescent Health, and Children with Special Health Care Needs. The other sections (Genetics, Immunization Program CHILD Profile, and MCH Assessment) focus on issues that encompass the entire MCH population. Following is a brief description of the basic role of each OMCH section. The Administration section is the seventh section in the office and supports all of the specialized sections. Funding is provided through a combination of sources including Title V, State General Funds, the Centers for Disease Control and Prevention, and Title XIX Medicaid Administrative Match.

***//2010/Two of the sections in OMCH (Child and Adolescent Health and Maternal and Infant Health) are initiating a process to merge into one section and have started a strategic planning process to identify how functions will be aligned.//2010//***

#### Maternal and Infant Health (MIH)

MIH, comprised of 9.45 full time equivalents (FTEs), works to improve birth outcomes by promoting quality health and support services for women of childbearing age. MIH focuses on pregnant and post-partum women and their infants. MIH works to identify and implement effective strategies to protect and improve the health of women, infants and families in Washington State. MIH has two primary goals: 1) to support women of childbearing age in making choices to adopt and maintain healthy behaviors; and 2) to ensure that women and infants, especially those in vulnerable populations have equal access to quality health services that meet their needs. This work is accomplished through monitoring trends in data, and by maintaining a 1-800 hotline resource and referral number, working collaboratively with private and public healthcare partners and contractors to improve access and quality of health services.

***//2010/10.7 FTEs.//2010//***

#### Child and Adolescent Health (CAH)

CAH, with 14.1 FTEs, works to promote, support, and provide public health leadership for state and community-based systems that assure the health and well-being of children, adolescents, and families. Through its programs, CAH promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, promotion of social emotional wellbeing and mental health, and child care health consultation.

*//2009/12.8 FTEs, CAH is also working to promote school-based health centers.//2009//*

***//2010/10.5 FTEs, CAH also promotes health in early learning and school readiness.//2010//***

#### Immunization Program and Children's Health Immunization Linkages and Development (CHILD) Profile (IPCP)

In 2005 the Immunization Program merged with the CHILD Profile program to form the Immunization Program CHILD Profile (IPCP) section. IPCP is comprised of 24.6 FTEs. IPCP is

committed to two primary goals: 1) preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases; and 2) ensuring that parents, health care providers, and state and local health agencies are working together to promote healthy families and increase use of preventive health care for children from birth to age six years. The section has created partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Academy of Family Physicians, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions. IPCP maintains the states' Immunization Registry and coordinates the Health Promotion System for parents of young children.

#### Children with Special Health Care Needs (CSHCN)

The CSHCN section has a total of 11.0 FTEs. The program promotes integrated systems of care that ensure that children with special health care needs and their families have the opportunity to achieve the healthiest life possible and develop to their fullest potential. CSHCN staff provide leadership in addressing health system issues that affect this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies and contractual relationships with LHJs, private and non-profit agencies, the University of Washington, Children's Hospital and Regional Medical Center (CHRM), other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, provider education, and family leadership development. A small amount of funding is used for medically necessary services and equipment for children whose families are at or below the Federal Poverty Level for Medicaid not covered by any other source of payment.

***/2010/11.5 FTEs. CHRM is now called Seattle Children's./2010/***

#### Genetic Services

Genetic Services, with 8.0 FTEs, is focused on assuring high quality comprehensive genetic services and early hearing-loss detection, diagnosis, and intervention (EHDDI) throughout the state. In these areas, this section serves as a resource for accurate, up-to-date information, promotes educational opportunities for health and social service providers, and evaluates quality, trends, and access to services.

***/2010/Genetic Services has 7.0 FTEs./2010/***

#### MCH Assessment (MCHA)

This section, with 12.65 FTEs, provides data, analysis, research, surveillance, and consultative support and management of all assessment activities within OMCH. Specific activities include leading the Five Year Needs Assessment process, reporting performance measures and health indicator status data; administering and analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) data and developing data reports; collecting and analyzing data from child death reviews, cluster investigations, and birth defects surveillance; and implementing State Systems Development Initiative activities. MCHA also designs and implements surveys and responds to data requests from OMCH, other programs within the Department of Health, local health jurisdictions, and other external stakeholders.

***/2010/MCHA works collaboratively with its sister sections within the larger OMCH program. MCHA has epidemiologists who act as liaisons to and advisors for other OMCH sections in order to efficiently and effectively provide technical assistance. Routinely, MCHA staff meets with the staff and director from each of the other OMCH programs to discuss and interpret data related to the program. Together they review data on past performance and***

***set future objectives and targets for the program. This assures that the program's objectives and targets are based on data trends across multiple years and on past, present and anticipated program activities.***

***During the MCH Block Grant application process, the grant lead for MCHA meets with program staff and directors to discuss and interpret data. In addition, the MCHA Block Grant lead consults and works in collaboration with staff from non-MCH programs and outside state agencies to solicit additional data needed to complete the grant application and report. MCHA sees the consultation and collaboration described above as critical to OMCH's overarching goal of protecting and improving the health of the MCH population of Washington State and to complete of the Block Grant application and report.***

***MCHA has 12.35 FTEs.//2010//***

### **C. Organizational Structure**

The Department of Health (DOH) is located within the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions, one of which is Community and Family Health. The Office of Maternal and Child Health (OMCH) is one of four offices within this division. In Washington State, the Children with Special Health Care Needs Program is part of OMCH.

DOH, through the Office of the Assistant Secretary for Community and Family Health and OMCH is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V (Section 509(b)). All programs funded by the Federal-State Block Grant partnership are included under this administration (Form 2, Line 8)."

For a Department of Health organization chart, go to the following internet link:  
<http://www.doh.wa.gov/Org/org.htm>

For a Division of Community and Family Health organization chart, go to the following internet link: <http://www.doh.wa.gov/cfh/CFHOrgChart/CFHorg.htm>.

For an Office of Maternal and Child Health organization chart, go to the following internet link:  
<http://www.doh.wa.gov/cfh/mch/documents/MCHOrg.pdf>.

***//2010/These organizational charts are also attached.//2010//  
An attachment is included in this section.***

### **D. Other MCH Capacity**

The Office of Maternal and Child Health (OMCH) has a total of 83.95 FTEs with staff in a variety of specialty areas including: epidemiology, public health administration, public health nursing, social work, oral health, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology. OMCH also employs a parent of a child with special health care needs as a full-time family consultant for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level. OMCH's Family Consultant takes a leadership role in activities to increase family involvement in children with special health care needs (CSHCN) policy and program development, including implementation of the family leadership strategic plan to increase integrated systems of care for CSHCN and their families. The Family Consultant also develops and manages contracts, grants, and other program activities related to children with special health care needs and the broader maternal and child health population. The current Family Consultant for OMCH is one of four delegates from Washington to the Association of

Maternal and Child Health Programs (AMCHP). The family perspective is an integral component of developing high quality, culturally competent programs and public policy.

The majority of staff are located in Olympia, Washington. The Genetic Services section is located in Kent, Washington, near Seattle.

Following are brief biographical sketches of DOH senior management and managers within OMCH:

Mary Selecky has been the Secretary of Health for nine years. She is a political science and history graduate of the University of Pennsylvania and past president of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the North East Tri-County Health District in Eastern Washington.

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and president of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington, School of Medicine and is on the MCH faculty at the University's School of Public Health and Community Medicine. In October 2006, Dr. Maxine Hayes was elected to the Institute of Medicine of the National Academies. The Institute is the principal advisor to the federal government, health care organizations and research institutions on health policy.

Mary Wendt is the Assistant Secretary for the Division of Community and Family Health. Mary joined DOH after nearly eight years with the Washington State Department of Social and Health Services (DSHS), most recently serving as the Chief Financial Officer for the Mental Health Division. Her prior roles with DSHS include serving as the Office Chief for the Office of Rates Development, where she oversaw professional-level analysts in charge of setting reimbursement rates and policies for the state's Medicaid program. She has also served as the Rural Health Clinic and Federally Qualified Health Center Program Manager for DSHS. Mary has a Master's in Public Administration: Health Administration from Portland State University and a Bachelor's Degree in Biology and Chemistry from the University of Utah.

Jennifer McNamara is the Chief Administrator for Community and Family Health at the Washington State Department of Health. Jennifer is a certified Project Management Professional, past manager of the Department of Health Project Resource Center, and is a twenty five year veteran of state government, serving both Department of Information Services and Department of Transportation previously.

Riley Peters, PhD became the Director of the Office of Maternal and Child Health (OMCH) in June 2007. Dr. Peters has a PhD in epidemiology from the University of Washington. He also holds a Master's in Public Administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 20 years and served as the manager of the MCH Assessment section for four years prior to becoming the director of OMCH.

Kathy Chapman, manager of the Maternal and Infant Health section, has a Master's degree in maternal and child health nursing from the University of Washington. She was previously the manager of the Children with Special Health Care Needs Section and also supervised the MCH Assessment Section for several years. Kathy has worked for more than 20 years in state and local public health programs focusing on maternal and child health issues.

Debra Lochner Doyle, manager of the Genetic Services section, has a Bachelor of Science degree in genetics from the University of Washington and a Master of Science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board

certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past president of the National Society of Genetic Counselors and a founding member of the Coalition of State Genetic Coordinators.

Maria Nardella is the manager of the Children with Special Health Care Needs section. Maria has more than 20 years experience in state CSHCN programs. She is a Registered Dietitian with a Bachelor of Science degree in nutrition from Cornell University and a Master of Arts in nutrition and mental retardation from the University of Washington, including clinical training at the university-affiliated program.

Judy Schoder became manager of the Child and Adolescent Health section in June 2006. She received a Bachelor of Science degree in nursing from Idaho State University in Pocatello, Idaho and a Master of nursing degree from the University of Washington. Judy was previously the adolescent health consultant for the Washington State Department of Health for 18 years. Prior to working at DOH, Judy was a public health nurse in Ithaca, New York.

***//2010/Kathy Chapman is now managing the Child and Adolescent Health Section, as well as the Maternal and Infant Health Section. These sections are beginning a process to integrate into one section.//2010//***

Janna Bardi, manager of the Immunization Program CHILD Profile section, has a Master's in Public Health in behavioral science and health education from the University of California, Los Angeles. She was previously the manager of the CHILD Profile section before it merged with the immunization program in 2005. She has experience in program analysis, policy development, systems development, inter-and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute.

*//2009/Shumei Yun, MD, PhD, senior epidemiologist/Manager of the MCH Assessment section, holds a MD and a Master's in Public Health from Beijing Medical University, and a PhD in nutritional epidemiology from the Cornell University. She joined the Washington State Department of Health in July 2008. Prior to moving to Washington, she worked as a state chronic disease epidemiologist in Missouri for five years.//2009//*

## **E. State Agency Coordination**

Working with offices and programs throughout DOH:

- 1) MCH Assessment (MCHA) and other epidemiology staff meet monthly to set standards for assessment functions, coordinate assessment activities, and facilitate communication within DOH. This collaboration has resulted in improved coordination with the Center for Health Statistics and local health jurisdiction (LHJ) assessment staff. MCHA works with the Family Violence Prevention Workgroup, which also includes representatives from Injury Prevention Program (IPP), Emergency Medical Services, and Family Planning and Reproductive Health Programs (FPRH). They meet monthly to coordinate activities and plan, evaluate, and secure resources to decrease family violence. The Tobacco Control and Prevention Program (TCP) works closely with the Pregnancy Risk Assessment Monitoring System (PRAMS) survey by helping to fund the survey and providing guidance on tobacco-related questions and analysis.
- 2) Children with Special Health Care Needs (CSHCN) works with the Women, Infants, and Children (WIC) to coordinate coverage for special formulas for children covered by Medicaid, and provide cross-training; and with Newborn Screening program (NBS) to ensure coverage for nutrition products for children with metabolic disorders.
- 3) Healthy Child Care Washington (HCCW) works with Environmental Health (EH), Immunization Program CHILD Profile, and Child Death Review (CDR) on SIDS prevention and oral health. TCP collaborates with CAH on developing the Healthy Youth Survey and provides major funding for

this survey.

/2009/Child and Adolescent Health (CAH) works with the Oral Health Program and Health Promotion (HP). CAH administers the Early Childhood Comprehensive Systems (ECCS) Grant and works with all OMCH sections to improve systems across the 5 required ECCS components. In promoting the development of school-based health centers (SBHC), CAH coordinates with HP and other stakeholders, on implementation of the Coordinated School Health Grant.//2009//

***/2010/CAH works with HP on lead screening for children in child care. CAH staff serve as the state CDR coordinator and work with MCHA, IPP and the Injury Prevention and Family Violence Prevention Workgroups.//2010//***

4) Maternal and Infant Health (MIH) works with Rural Health on women's health, access to obstetric care, and domestic violence prevention. MIH collaborates with HIV/AIDS, family planning and other contractors through the MCH/HIV Workgroup (HIVWG). HIVWG focuses on developing effective policies and programs for HIV/AIDS prevention and care in the MCH population and increasing the number of medical providers who recommend HIV testing for all pregnant women. MIH works with FPRH to reduce unintended pregnancies and promote the Medicaid Take Charge Program. MIH joins with TCP to develop the Maternity Support Services (MSS) tobacco cessation project and train providers. The two programs collaborated to successfully advocate for improved Medicaid coverage of smoking cessation treatment for pregnant women. TCP provides funds to the WithinReach toll-free Family Health line, which asks callers about tobacco use and includes Tobacco Quit Line information in their prenatal and child health education packets. They also fund MIH to exhibit tobacco-related materials at continuing medical education events. MIH works with WIC to promote breast-feeding, exchange data, enhance referrals, and address access to care issues between WIC and First Steps. MIH provides training and materials to WIC program staff on methods for identifying and intervening with victims of domestic violence and child abuse. MIH and WIC have collaborated to revise the parent education booklet titled, Nine Months to Get Ready, used for client education by WIC and MSS providers. MIH leads a cross-division workgroup on preconception health, which includes representatives from infectious disease, FPRH, chronic diseases and HP. The Women's Health Resource Network (WHRN) is a forum for DOH-wide input and response to current and emerging women's health issues and service gaps including data on women's health, policy related to program services, quality assurance and standards development, and changes in the health care system. Their goal is to assist in building state and local capacity to address the needs of women and their health concerns throughout their lives. WHRN includes representatives from 16 Community and Family Health and EH programs.

5) Genetic Services Section (GSS) early hearing loss detection, diagnosis, and intervention (EHDDI) staff are co-located with NBS dried blood spot staff at the Public Health Laboratory. This allows for strengthened networking and the sharing of resources for similar procedures.

6) Immunization Program CHILD Profile (IPCP) works with Environmental Health and Safety to determine priority environmental health risks for children and develop educational materials to increase parental knowledge of how they can protect their children from several environmental toxins. Environmental Health Assessments and CHILD Profile developed the Protect Kids from Toxics brochure which explains the risks of ingesting high levels of mercury and how to limit exposure to mercury and other toxic substances. The Lead Can Poison Your Child insert was developed to educate parents about lead exposure and testing. IPCP has an agreement with the Communicable Disease Epidemiology Program to provide rash illness investigation and reporting. CHILD Profile partners with IPP to provide product safety messages to parents with children between birth and six years of age. WIC and IPCP collaborate on nutrition materials for CHILD Profile mailings and share information about emergency preparedness planning. IPCP works with WIC to comply with federal requirements and enhance immunization rates.

***/2010/IPCP works with TPC to include information on Second Hand Smoke prevention in***

***mailings to parents and with programs throughout DOH, including First Steps and FPRP, to ensure that children have access to vaccines. We work with emergency preparedness staff to develop systems for use in emergency events that include vaccines as a response measure.//2010//***

7) MCH Administration and the Oral Health Program (OHP): Multiple programs in OMCH work with IPP, and OMCH uses Title V Block Grant funds to partially fund data collection and reporting of intentional and unintentional injuries, youth suicide, and family violence. OHP works with Rural Health, Facilities and Services Licensing, and Health Professions Quality Assurance to increase access to dental care and promote dental homes within medical homes. OHP collaborates with EH, Epidemiology, HP, and HIV/AIDS to enhance preventive oral health care and address unmet needs. OMCH also works with Drinking Water on fluoridation. MSS educates providers regarding pregnancy and oral health and makes educational materials available to women receiving Medicaid.

***/2010/The Dental and Dental Hygiene Boards and Rural Health are partners in the State Oral Health Plan.//2010//***

Working with other state agencies

1) Washington State Board of Health (SBOH) is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. OMCH works with SBOH on children's health issues and rulemaking activities. Topics addressed include newborn screening; prenatal screening, HIV testing of pregnant women, immunization requirements for school and child care attendance, genetics, and hearing, vision, and scoliosis screening in schools. OMCH and SBOH staff serve on a mental health advisory committee convened by the Governor's office.

/2009/OMCH provided input into the SBOH paper on a public health approach to mental health, developed for the Mental Health Transformation Project in 2007.//2009//

***/2010/SBOH is a partner in the State Oral Health Plan and participates on the Medical Home Partnership Committee hosted by CSHCN.//2010//***

2) Department of Social and Health Services (DSHS): OMCH programs collaborate with many facets of DSHS to maximize federal administrative match, build on each others strengths to promote the best outcomes for clients, generate and use data needed by both agencies, provide coordinated program services for clients, provide complementary services, and avoid duplication. An agreement between Health and Recovery Services Administration (DSHS-HRSA) Title XIX (formerly MAA) and OMCH has existed for 14 years. Partnerships between OMCH and DSHS-HRSA have developed with the mutual goal of assuring quality health services for pregnant women, infants, children, and adolescents served by Medicaid. We expect that recent changes in Medicaid administrative match allowances will reduce funding for these activities. The following are examples of the many ways we work with DSHS-HRSA.

OMCH participates on the Medicaid External Quality Review Organization Contract committee, DSHS-HRSA Early Periodic Screening Diagnosis and Treatment (EPSDT) Improvement Committee, and DSHS-HRSA Immunization Partnership Committee. In 2007, OMCH worked with DSHS-HRSA to facilitate a statewide EPSDT Improvement Summit.

***/2010/OMCH participates in the Children's Healthcare Improvement System Steering, Vaccines, and Developmental Screens and EPSDT Committees.//2010//***

/2009/MIH manages the Medicaid MSS and childbirth education programs. These programs target women under 185% Federal Poverty Level. The CSHCN manager serves on the Title XIX Interagency Advisory Committee.//2009//

CSHCN partners with DSHS-HRSA and LHJs to work with Medicaid managed care plans to meet requirements of the Centers for Medicare and Medicaid Services (CMS) 1915B waiver requiring DSHS-HRSA to identify, track, and coordinate care for children in managed care who are also served by Title V, and to allow families to request an exemption from managed care if needed. Plan representatives have become a part of the quarterly CSHCN Communication Network meetings. CSHCN is also working with managed care plans to identify practical ways for providers to develop and provide medical homes for all children. DOH works with DSHS-HRSA and Health Care Authority to develop performance measures for providers, health plans, and other partners involved in health care delivery, especially publicly funded health coverage.

DSHS-HRSA provides administrative match for PRAMS activities not covered by the Centers for Disease Control and Prevention grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services. IPCP's partnership with DSHS-HRSA resulted in matching funds for IPCP activities, data sharing agreements, and DSHS-HRSA participation in developing health promotion materials for parents and in the CHILD Profile Advisory Group. DSHS-HRSA and IPCP are working together to maintain and expand partnerships with the state's health plans. CSHCN works with DSHS-HRSA to improve access to and quality of health services for children with special health care needs through CSHCN Communication Network meetings and to implement quality assurance measures and data sharing for Title V children in Medicaid managed care. CSHCN assists DSHS-HRSA with implementing recently expanded publicly funded health coverage for children.

/2009/Expansion of publicly funded health coverage includes provision of care within a medical home. New legislation in 2008 will fund primary care pilots to implement medical home for all patients using a learning collaborative model currently being used by DOH in CSHCN medical home teams.//2009//

IPCP works extensively with DSHS-HRSA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children receive adequate immunizations. OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH oversees the program and works with DSHS-HRSA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for new parents up to 90 days after birth.

OHP collaborates with DSHS-HRSA on access to dental services for children receiving Medicaid services. OMCH and DSHS-HRSA both participate on a statewide oral health coalition and meet together regularly on the Access to Baby and Child Dentistry (ABCD) Initiative and other access issues.

***/2010/DSHS-HRSA is a partner in the State Oral Health Plan and attends CSHCN meetings.//2010//***

OMCH participates with the Division of Alcohol and Substance Abuse on an oversight committee for developing, implementing, and evaluating a comprehensive treatment program for chemically dependent pregnant or parenting women and their young children.

OMCH works with the Children's Administration (CA), which includes Child Protective Services (CPS), Child Care, Foster Care, and other offices on subjects of joint concern. These include chemically dependent pregnant women, child maltreatment, CDR, and mental health. A cross-office/cross-agency group meets to improve services and coverage for children in foster care who are considered to be children with special health care needs.

OMCH works with CA, the Mental Health Division (MHD), and the University of Washington (UW) to train foster parents to use the Bright Futures mental health materials.

/2009/The foster parent training project ended August 2007. Child care was moved to DEL when it was created in 2006.//2009//

OMCH continues to provide MHD with data to comply with CMS requirements for the Medicaid 1915B waiver. This information provides the means to identify the number of children with special health care needs served by both Title V and MHD. DOH is represented by OMCH staff on the Children's Treatment and Services subcommittee of the MHD Mental Health Planning and Advisory Committee.

CSHCN maintains a memorandum of understanding with Disability Determination Service (DDS) and Social Security Administration in order to provide information to families of children under the age of 16 years who apply for Social Security Income (SSI). DDS provides data files of all SSI applicants up to age 16 years to the CSHCN program.

OMCH participates with the Division of Developmental Disabilities' Infant Toddler Early Intervention Program in coordinating efforts to implement Part C of the Individuals with Disabilities Education Act. Through an agreement with DSHS, the Department of Community, Trade, and Economic Development (CTED), the Department of Services for the Blind, and Office of Superintendent of Public Instruction, OMCH works to ensure a comprehensive statewide system of early intervention services for eligible infants and toddlers with disabilities (birth to 3 years) and their families. IPCP has an agreement with DSHS to distribute brochures that include development information for parents of children between age 3 and 18 months. The brochures provide parents with the resources to access early intervention services.

GSS works with the Office of the Deaf and Hard of Hearing to link members of the deaf and hard of hearing community to families with infants diagnosed with hearing loss.

3) Office of Superintendent of Public Instruction (OSPI): OMCH maintains many partnerships with OSPI. IPCP works with OSPI to distribute child development and school readiness information and with OSPI Health Services on issues involving immunization requirements for school entry. CSHCN participates in monthly OSPI school nurse corps meetings. Washington State received a Coordinated School Health (CSH) Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and CAH participate on the CSH Interagency Committee, and work to align this effort with related adolescent health and mental health planning initiatives. CSHCN works with OSPI to identify appropriate health outcomes for children with special health care needs, including participation in a new youth transition planning initiative, Building Bridges, being piloted in several school districts statewide, and targeting at-risk youth and those with special needs. OMCH participates on an interagency team called STEPS (Sequenced Transition for Education in Public Schools) that addresses transition issues for children birth to school age. Funding provided by OMCH to support some staff time for school nursing was cut in 2007. However, despite the cut in funding, OMCH and OSPI school nurse collaboration continues. School Nurse Corps supervisors participate in MCH Regional meetings. Representatives from multiple DOH programs, OSPI, CTED, DSHS, the Liquor Control Board, and the Governor's Family Policy Council make up the Healthy Youth Survey planning committee. These same organizations, along with other state and local agencies, are members of the Washington State Partnership for Youth (WSPY). WSPY's purpose is to develop a plan for improving adolescent health in Washington State. CAH collaborated with OSPI and other stakeholders to develop the Guidelines for Sexual Health Information and Disease Prevention as directed by the state Legislature.

//2009/OSPI and other stakeholders serve on the School-Based Health Center Interagency Group that OMCH convenes. A representative from OSPI also serves as a member of the Autism Task Force, which is supported by staff from OMCH.//2009//

***//2010/Due to statewide hiring freeze and staff vacancy, CSHCN is no longer participating in Building Bridges.***

***OSPI participates in the IPCP CHILD Profile Advisory Group and State Oral Health Plan.***

***CAH works with OSPI to review sexual health education curricula for adherence to the Healthy Youth Act as directed by the state legislature and to develop medical and scientific accuracy trainings for school personnel.***

***OSPI participates on the Combating Autism Advisory Council.//2010//***

4) Department of Early Learning (DEL) was created in 2006. OMCH has many partnerships with DEL including serving on the Early Learning Advisory Council and collaborating to provide health consultation to child care providers.

***/2010/DEL attends IPCP's CHILD Profile Advisory Group and provides a brochure for inclusion in CHILD Profile Health Promotion mailings.***

***ECCS and Project LAUNCH are collaborating with DEL, Thrive By Five and other stakeholders to create a new statewide Early Learning Plan.***

***DEL is a partner in the State Oral Health Plan.//2010//***

5) University of Washington (UW) and DOH collaborate in a project using the State Capacity Grant for Prevention of Secondary Disabilities. This project is supported by a cooperative agreement with the Centers for Disease Control and Prevention to assess the types and prevalence of secondary disabilities and form local advisory councils to promote a public awareness campaign and implement strategies to prevent secondary disabilities. GSS works with the UW Center for Health Policy and the Institute for Public Health Genomics on a variety of training and research endeavors. IPCP contracts with UW to evaluate the CHILD Profile (CP) Health Promotion System and maintain the CP website.

***/2009/The State Capacity Grant for Prevention of Secondary Disabilities ended in June 2008.//2009//***

OMCH uses MCH block grant funds to contract with programs within UW's Center on Human Development and Disability that receive Leadership Education for Neurodevelopmental Disabilities grants. These contracts extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, adolescent transition, medical home, and emotional behavior in very young children. CAH works with the UW School of Education, Early Childhood, and Teen Telecommunications Network to foster leadership on issues of parents and teens and pre-teens at the state and local levels. OHP works with the UW School of Pediatric Dentistry on oral health issues that impact pregnant women, infants, children, and youth.

***/2010/UW Schools of Dentistry and Medicine partner in the State Oral Health Plan.//2010//***

***/2009/6) Washington was one of seven states to receive a federal Mental Health Transformation Grant (MHT) in 2005. DOH, several sections of DSHS, OSPI, DEL, consumers, providers, and other stakeholders serve on the MHT Workgroup, which guides the implementation of the grant. DOH, OSPI, DSHS and SBOH participate on the MHT Prevention Advisory Group, working to promote a public health approach to mental health and increase capacity for prevention and early identification of mental health problems. OMCH works to keep public health and early learning stakeholders informed of opportunities to coordinate with and influence this work.//2009//***

***/2010/CAH works with the MHT Project and Public Health Seattle-King County to explore ways to increase mental health access and address provider reimbursement issues in SBHCs.//2010//***

***/2009/7) Council for Children and Families (CCF), previously the Washington Council for the Prevention of Child Abuse and Neglect, works to prevent child abuse and neglect before it happens (primary prevention) by promoting protective factors, including positive parent-child***

relationships, non-punitive discipline, and an understanding of child development. DOH, DSHS, OSPI, and DEL serve on the council along with other stakeholders.//2009//

***/2010/CCF partners with IPCP by providing shaken baby and post partum depression brochures for inclusion in the CHILD Profile Health Promotion mailings.***

***ECCS partners with CCF on the Strengthening Families Washington initiative to integrate five protective factors across early learning.***

***8) Washington State Developmental Disabilities Council and Office of the Education Ombudsman are partners on the CSHCN Autism Project.***

***9) The Insurance Commissioner, Department of Corrections, and Health Care Authority all partner in the State Oral Health Plan.2010//***

#### ***Working with Local Health Jurisdictions (LHJs) In Washington State***

***OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH program staff work closely with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs and other local MCH staff through quarterly MCH Regional meetings. DOH works with Public Health Nursing Directors to develop key activities, outcomes, and indicators for local public health OMCH provides technical assistance and data support for the local CDR teams throughout the state. Some of the activities provided by LHJs are described in the performance measure narratives. A report of LHJ activities is available by contacting OMCH at 360-236-3502 or mch.support@doh.wa.gov.***

***/2010/LHJs are partners in the State Oral Health Plan.//2010//***

#### ***Working with Hospitals and Other Specialized Services***

1) Children's Hospital and Regional Medical Center (CHRM) works with OMCH through a contract with the Center for Children with Special Needs to provide information to families, providers, and policy makers regarding health issues for children with special health care needs and their families. GSS also contracts with CHRM to provide technical assistance to birthing hospitals that are initiating or already conducting Universal Newborn Hearing Screening. CHILD Profile collaborates with CHRM to develop and disseminate injury prevention materials for parents of children birth to six years.

***/2010/CHRM is now called Seattle Children's (SC). IPCP collaborates with SC to develop and disseminate material on preventing and treating illness to parents of children age birth to six years.//2010//***

2) Mary Bridge Children's Hospital and Health Center (MB) is the site of one of 16 MCH supported neurodevelopmental centers and the Maxillofacial Review Team for Southwest Washington. Previously, MB assisted CSHCN in developing and disseminating guidelines to primary care providers for the care of high-risk infants as part of their discharge plan. However, the contract ended on 6/30/06 and was not renewed because of cuts in MCH block grant funding.

3) Regional Genetics Clinics (RGC): 17 RGCs are located throughout the state and are funded to provide clinical genetic services for the MCH population as well as educational outreach to their communities. Data generated by the RGCs are used for program planning and policy development.

4) Perinatal Regional Network (PRN): In 2007, cuts in Medicaid funding led to changes to the

regional perinatal program. It became PRN, which coordinates state and regional quality improvement projects to decrease poor pregnancy outcomes. Previously, the regional perinatal program operated through contracts between OMCH and four regional perinatal programs. These programs provided consultation and training to health care providers with a focus on specialized care for high-risk pregnant women and neonates.

5) Perinatal Advisory Committee (PAC), staffed by OMCH, brings together representatives from tertiary care centers, professional organizations, consumer groups, and state agencies to review and assess perinatal health issues and advise DOH and DSHS-HRSA in developing policies and practices to improve perinatal outcomes.

6) Community Health Clinics (CHC) play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are also First Steps providers and participate in First Steps education updates sponsored by OMCH and DSHS-HRSA. CHC Dental Clinics participate with OHP to collaborate on community-based preventive oral health programs such as school sealants and act as a referral base for WIC and Head Start children.

7) Neurodevelopmental Centers (NDC): CSHCN provides funding to support the infrastructure of 16 NDCs across the state. NDCs provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children with a variety of developmental or neurodevelopmental conditions. These non-profit centers depend on state funding to provide a structure for specialty services with support from other payers for services, other state agencies, and community resources.

***/2010/8) Madigan Army Medical Center partners on the CSHCN Autism Project.***

***9) The Yakima Valley Farm Workers Clinic is a partner in the State Oral Health Plan.//2010//***

*/2009/Working With Tribes*

OMCH works with the DOH tribal liaison to explore ways to expand and improve communication with tribes in Washington State. Specific actions include working with the American Indian Health Commission (AIHC), and expanded use of the DOH Tribal Connections website. In response to a joint DSHS/DOH data presentation to the AIHC, a subcommittee of the AIHC was formed to work on strategies to improve health outcomes in Native American mothers and children.

Representatives from DSHS, MIH, the First Steps program, WIC, and tribal liaisons have had two meetings to frame purpose and begin exchanging information. MCHA has worked closely with the Northwest Area Indian Health Board and the Seattle Urban Indian Health Institute on maternal and infant assessment issues. We have also worked on a joint project to improve birth certificate completion by Native American mothers and to improve response rates to the PRAMS survey//2009//

***/2010/The Indian Health Service (IHS) Portland Area Office and AIHC are partners in the State Oral Health Plan.//2010//***

Working with Communities, Foundations, and Organizations

1) Foundation for Early Learning (FEL) and IPCP work together to revise and distribute both the birth to 18 months and the 18 months to 4 years development charts for parents. These charts address social, emotional, physical, language, motor, and cognitive development and provide parents with specific activities that will support their child's development. FEL also partnered with CHILD Profile to distribute a booklet titled Getting School Ready to parents of 4-year olds. OMCH collaborated with FEL and the Head Start State Collaboration Office to develop Kids Matter, a strategic plan/framework for assuring children are healthy and ready for school.

***/2010/IPCP and FEL work together to distribute a booklet on school readiness in the CHILD Profile Health Promotion mailings./2010//***

2) Sensory Disabilities Services: GSS contracts with Washington Sensory Disabilities Services to train providers across the state to work with children who are deaf or hard of hearing, and to conduct a birth-to-three educational module at their annual Deaf Family Weekend.

/2009/3) Epilepsy Foundation Northwest and CSHCN are collaborating in a three year grant awarded to DOH intended to improve community-based system of services for children and youth with epilepsy. Grant activities will focus on medically underserved and rural areas of central Washington, and target communities with a significant Hispanic population./2009//

***/2010/4) Thrive by Five Washington partners with ECCS in creating an Early Learning Plan for Washington, building on the Kids Matter framework: health, social-emotional development and children's mental health, early care and education, parenting and family support.***

***5) Reach Out and Read Washington partners with ECCS to integrate medical home into health and early literacy activities.***

***6) Health care provider associations: IPCP works with health care provider associations, including the Washington Chapter of the American Academy of Pediatrics, Washington Association of Family Physicians, and the Washington Medical Association, to provide information on best practices for immunization, quality assurance activities around vaccine use, and special projects to increase immunization rates.***

***The Washington Alliance of Dental Hygiene Practitioners, Association of Community and Migrant Health Centers, State Dental Association, and State Dental Hygienists' Association are partners in the State Oral Health Plan.***

***7) WithinReach, the state's Healthy Mothers, Healthy Babies organization, works with IPCP to provide information on child health and immunizations and immunization outreach activities through the Immunization Action Coalition of Washington. WithinReach also sponsors an insert on how to access health insurance in the CHILD Profile Health Promotion mailings.***

***8) Washington Dental Service Foundation (WDSF) works with IPCP to insert a brochure on oral health in the CHILD Profile Health Promotion mailings. WDSF is a partner in the State Oral Health Plan.***

***9) Washington State Dairy Council works with IPCP to insert a brochure on children's nutrition in the CHILD Profile Health Promotion mailings.***

***10) The Autism Society of Washington, Autism Speaks Washington, Family Voices of Washington, Washington PAVE, the Family to Family Health Information Center, and Easter Seals partner with CSHCN on their Autism Project.***

***11) The Washington Dental Service, Washington State Oral Health Coalition, and the Medical Home Group partner in the State Oral Health Plan./2010//***

## **F. Health Systems Capacity Indicators**

### **Introduction**

The Health Systems Capacity Indicators (HSCI) are a group of national indicators designed to measure the capacity of each state to serve certain populations. They address both access and availability to services and programs, often by Medicaid and SCHIP eligibility, and are measured

annually. Each HSCI includes a discussion of the factors influencing whether the HSCI has been maintained or has improved, the efforts being made by the program to develop new strategies, interpretations of the data trends, and any association between the measure and the State Systems Development Initiative (SSDI) grant.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 27.8        | 29.2        | 25.3        | 21.6        |             |
| Numerator   | 1113        | 1187        | 1042        | 909         |             |
| Denominator   | 400939      | 405992      | 412285      | 420384      |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

Data not available for 2008.

**Notes - 2007**

Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The data was accessed using VISTAPHw software.

**Notes - 2006**

Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The data was accessed using VISTAPHw software.

**Narrative:**

Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. Hospitalization rates for asthma include only in-patient hospitalizations. While rates have fluctuated over the past five years (decreasing from 2000 to 2003, but increasing slightly in 2004 and 2005), the trends show an overall decrease which is reflected in the most recent data from 2006.

***/2010/Rates have fluctuated over the past seven years (generally decreasing from 2000 to 2003, but increasing slightly in 2004 and 2005), the overall trend shows a statistically significant decrease which has continued with the most recent data available for 2007./2010//***

OMCH promotes awareness and prevention of asthma issues in young children through the promotion of Bright Futures guidelines as the standard for well-child care, the promotion of medical home for all children, and the system of child care health consultation (Healthy Child Care Washington). Child care health consultants are public health nurses who are knowledgeable

about asthma recognition and treatment; and they assist child care providers to recognize, cope with, and prevent asthma, and to work with parents. Child care health consultants also address issues of obesity and physical activity, and providing healthy environments for young children, all of which can prevent or reduce the severity of asthma. Healthy Child Care Washington accesses the latest medical information on asthma through its pediatric health advisor, and connections with the American Academy of Pediatrics. The Promoting Bright Futures in Washington initiative is working with the Medical Home Leadership Network to address asthma and other chronic disease issues, with parents and health care providers.

OMCH is the recipient of an Early Childhood Comprehensive Systems (ECCS) grant which it used to develop a partnership and strategic plan/framework (Kids Matter) focused on improving health and health care in early childhood. OMCH also participates in other partnerships to improve children's health, such as the public-private partnership called Thrive by Five, and the multi-agency group that aims to improve the use of Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

***//2010/Child care health consultants have added to their knowledge through environmental health trainings, including The National Healthy Homes Training Center, Master Home Environmentalist, and the Institute on Creating Sustainable Environments for Young Children. Healthy Child Care Washington data indicate that child care providers are making changes in their environments that can reduce asthma, such as going shoeless inside, and using non-irritating cleaning products. Consultants also help with care plans and general training on methods of administering medications. OMCH works with the DOH Office of Health Promotion to develop and distribute materials for parents and caregivers of young children on environmental health issues.//2010//***

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 98.6        | 99.1        | 99.0        | 99.1        |             |
| Numerator   | 35011       | 36986       | 38087       | 43527       |             |
| Denominator   | 35509       | 37322       | 38472       | 43923       |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

No data are available for 2008.

**Notes - 2007**

These data are based on the Washington State 2007 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and residents who live in counties without a managed care option.

## **Notes - 2006**

These data are based on the Washington State 2006 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and residents who live in counties without a managed care option. The 2006 HEDIS percentage was used as an estimate for 2007, since no new data are available.

### **Narrative:**

In 2006, 99.0% of Medicaid enrollees less than age one year had at least one initial periodic screen. These data, which were gathered from the Department of Social and Health Services (DSHS) 2006 HEDIS Report, reflect an increased proportion of Medicaid enrolled infants since 2000 who received at least one periodic screening. However, data collection methodology has not been constant in recent years and caution should be taken when interpreting trends.

***/2010/In 2007, 99.1% of Medicaid managed care enrollees less than one year of age had at least one initial periodic screen. These data, which were gathered from the DSHS 2007 HEDIS Report, continue to show the increase, since 2000, in Medicaid enrolled infants who have received at least one periodic screening. However, data collection methodology has not been constant in recent years and caution should be taken when interpreting trends./2010//***

First Steps Maternity Support Services (MSS) providers serve about 70% of women eligible for Medicaid paid prenatal care and delivery. First Steps Maternity Support Services providers assist women to identify a healthcare provider for their infant prior to delivery and support women for 2 months postpartum in keeping well child exams. Families eligible for Infant Case Management continue to receive support, reinforcement and referrals as necessary for well child care up to one year of age.

***/2010/Statewide budget reductions will impact the percent of women who may be served by these programs in 2010./2010***

***The federal Early Childhood Comprehensive Systems Grant (ECCS) and Kids Matter, the partnership and strategic plan/framework developed through ECCS, continue to identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys continue to show a variety of state and local stakeholder activities are being implemented related to this goal. Kids Matter partners and other representatives from OMCH participated in a new project from WithinReach that assists parents and families to access medical coverage, and promotes children receiving periodic health screens.***

***The ParentHelp123.org website is inviting and interactive, helping thousands of families assess their potential eligibility for state benefit programs, including Medicaid and Food Stamps, and fill out program applications on-line. This web resource provides low-income families with a single access point to free and low-cost health insurance, food assistance and many other resources--all in one place, 24 hours a day. In a one-year period, over 32,000 people visited www.ParentHelp123.org and 8,000 families were screened for potential program eligibility using ParentHelp123's Benefit Finder and over 4,000 applications were completed.***

***/2010/The WithinReach project assisting parents and families to access medical coverage and promote periodic health screens ended in 2005. The number of people accessing ParentHelp123.org, using its screening tool, and completing applications has remained***

**consistent./2010//**

The Maternal and Infant Health (MIH) Section seeks to improve the percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen through supporting the Family Health hotline operated through an organization called WithinReach. The hotline refers parents to resources to help them enroll in and access Medicaid services for their children. In addition, First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) have developed a new strategic plan which focuses on populations where health disparities exist.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 0.0         | 0.0         | 0.0         | 0.0         |             |
| Numerator   | 0           | 0           | 0           | 0           |             |
| Denominator   | 1           | 1           | 1           | 1           |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

Data are unavailable for 2008.

**Notes - 2007**

Data are unavailable for 2007. We don't expect to be able to report on this measure for 2007 because data specific to SCHIP enrollees are not available through HEDIS for this age group. Washington SCHIP covers from 200 to 250% of the poverty level. In Washington, children are covered by SCHIP and Medicaid in much the same way. There is no reason to suspect a difference in levels of coverage.

**Notes - 2006**

HEDIS Data was unavailable for 2006. In 2006 there were approximately 180 children less than 15 months during the reported year who were covered by the State Children's Health Insurance Plan. However, we don't expect to be able to report on this measure for 2006 because data specific to SCHIP enrollees are not available through HEDIS for this age group. Washington SCHIP covers from 200 to 250% of the poverty level.

**Narrative:**

Data are unavailable. Data for this indicator (HSCI03) have been gathered from the DSHS HEDIS Report. However, data from previous years reflected all SCHIP enrollees 0-18 years. In 2006, there were approximately 180 children less than 15 months covered by SCHIP, about half of whom were enrolled in managed care plans. Their well-child experience is included in HEDIS, but

because the numbers are so small, a separate estimate for children less than 15 months on SCHIP is not available.

***/2010/In 2007, there were approximately 189 children less than 15 months covered by SCHIP, most of who were enrolled in managed care plans. Their well-child experience is included in HEDIS, but because the numbers are so small, a separate estimate for children less than 15 months on SCHIP is not available./2010//***

OMCH is in a different agency than the SCHIP program; OMCH collaborates with DSHS, but does not directly control the SCHIP program.

First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) also refer and link SCHIP eligible children to providers who offer periodic screening services, including immunizations and well-child care.

***/2010/Statewide budget reductions will impact the percent of Medicaid-eligible women and infants who can be served by the First Steps program./2010//***

The federal Early Childhood Comprehensive Systems (ECCS) grant and Kids Matter, the partnership and strategic plan/framework developed through ECCS, continue to identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys continue to show a variety of state and local stakeholder activities are being implemented related to this goal. Kids Matter partners and other representatives from OMCH participated in a new project from WithinReach that assists parents and families to access medical coverage, and promotes children receiving periodic health screens. The ParentHelp123.org website is inviting and interactive, helping thousands of families determine their eligibility for state benefit programs, including Medicaid and Food Stamps, and fill out program applications on-line. This web resource provides low-income families with a single access point to free and low-cost health insurance, food assistance and many other resources-all in one place, 24 hours a day. In a one-year period, over 32,000 people visited www.ParentHelp123.org and 8,000 families were screened for potential program eligibility using ParentHelp123's Benefit Finder and over 4,000 applications were completed.

***/2010/The WithinReach project assisting parents and families to access medical coverage and promote periodic health screens ended in 2005. The number of people accessing ParentHelp123.org, using its screening tool, and completing applications has remained consistent./2010//***

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

***/2010/Eligibility for a seamless system now called, Apple Health, covers all children in the state to 300% FPL./2010//***

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b> | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator                             | 61.6        | 68.0        | 66.3        | 64.8        |             |
| Numerator                                    | 41243       | 43866       | 47222       | 49154       |             |

|   |       |       |       |       |  |
|---|-------|-------|-------|-------|--|
| Denominator   | 66926 | 64482 | 71244 | 75895 |  |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |       |       |       |       |  |
| Is the Data Provisional or Final?   |       |       |       | Final |  |

#### **Notes - 2008**

No data are yet available for 2008.

#### **Notes - 2007**

These data were obtained from the First Steps Database, Washington State Department of Social and Health Services, and are gathered from 2007 Washington State Birth Certificate files.

The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

#### **Notes - 2006**

These data were obtained from the First Steps Database, Washington State Department of Social and Health Services, and are gathered from 2006 Washington State Birth Certificate files.

The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

#### **Narrative:**

Data collection of first trimester entry to prenatal care changed in Washington in 2003 with our adoption of the 2003 revisions to the US Standard birth certificate. (Washington State was a leader in adopting the new version; there is no deadline for states to change to the new revision). For this reason, these data are not comparable to earlier data, and are not comparable to current US data, nor data collected from most other states.

***/2010/Since 2003 this indicator has been fluctuating, with the last two years, 2006 (66.3%) and 2007 (64.8%), reflecting a downward trend from its apex in 2005 (68.0%).//2010//***

Approximately 38% of all women (Medicaid and Non-Medicaid) who began prenatal care after the first trimester could not get prenatal care as early as they wanted according to 2004-2006 Washington data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS). Barriers to early care reported by these women include: not having enough money or health insurance to pay for care (about 41%); not having a Medicaid card, Healthy Options card or medical coupon (about 40% of women whose prenatal care and/or delivery was paid for by Medicaid); not being able to get an appointment when they wanted one (about 36%); not knowing they were pregnant (about 32%) (2002-2003 data); no transportation to clinic or doctor's office (about 17%); no one to care for other children (about 15%); and doctor or clinic would not start as early as wanted (about 13%).

***/2010/First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. First Steps Maternity Support Services provides services to promote early and continuous prenatal care for Medicaid eligible pregnant women. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.***

***The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. In FFY 2008, 6,593 pregnant women called the FHH. Of these callers, 1,735 were already receiving prenatal care. A total of 7,800 related referrals were given to these callers.//2010//***

Additional system-wide barriers to providing early prenatal care include the recent increase in both Washington State's overall number of births, and in the percent of births covered by Medicaid. Both have increased by about 10% since 2002, and we have no data to see whether the numbers of obstetric providers have also increased.

***/2010/Data from the Department of Social and Health Services First Steps Database show an overall decrease in the number of obstetric providers from 2003 to 2006. That report shows that overall the number of obstetric providers decreased by 13% between 2001 and 2006. The decrease is particularly acute for Family Practice physicians who provide obstetric care.//2010//***

OMCH seeks to increase the percent of women (ages 15-44 years) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index through supporting MSS services that aim to get women into early and continuous prenatal care. It is a goal to refer women to prenatal care as soon as they enroll in Medicaid. Also, the Family Health toll-free line refers women for care and insurance (i.e. Medicaid) for prenatal services. The Department of Social and Health Services identifies Medicaid eligible women in their databases who are not receiving MSS or prenatal care and refers them to local providers.

***/2010/WithinReach and DOH are working on new activities to increase awareness about the importance of prenatal care and the availability of First Steps and other programs for pregnant women. These activities include enhancing the information for pregnant women on WithinReach's ParentHelp123.org website, implementing an on-line tool that pregnant women can use to find First Steps providers near them, educating health care providers about the services WithinReach can provide to their clients, and improving the information about First Steps given out on Family Health Hotline. They are also doing research to identify possible outreach methods for future use.***

***DOH and DSHS are working on strategies to improve identification and referral of high risk pregnant women who apply for Medicaid services.***

***Maternal and Infant Health (MIH) has presented information on declining prenatal care access to several local community groups and the statewide Perinatal Advisory Committee. MIH has also worked with targeted communities to develop community level strategies for improving prenatal care access, particularly for Medicaid women. This includes working with the African American and Native American population.//2010//***

MIH provides information on our website regarding resources for women seeking prenatal care.

The Center for Health Statistics continues to work with hospitals to work on completeness of birth record data. The Birth Data Quality Query System allows each birthing hospital to check on how complete their data currently is for selected birth certificate items. Hospitals can see how they compare to the state as a whole or to hospitals with similar birth volumes and how their data quality has changed over time.

***Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.***

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 86.5        | 87.3        | 88.0        | 88.5        |             |
| Numerator   | 600174      | 590014      | 593536      | 590175      |             |
| Denominator   | 694133      | 676232      | 674373      | 666834      |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

#### **Notes - 2008**

Data are not available for 2008.

#### **Notes - 2007**

Technical Note: The source of these data is the Client Services Database, Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management. The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

\*SCHIP children are included in managed care

\*Data is gathered from the Client Service Database, which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being enrolled in a managed care plan counts as receiving medical services, regardless of whether the child visited a health professional or not.

Medically Eligible Title XIX description:

Clients who are eligible to receive medical services for which the state receives federal Title XIX matching funds. Title XIX of the Social Security Act funds:

- (1) medical assistance on behalf of families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and of aged, blind, or disabled individuals.
- (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

#### **Notes - 2006**

2005 Indicator – 88.0%

Numerator - 593536

Denominator - 674373

Technical Note: The source of these data is the Client Services Database, Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management. The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

\*SCHIP children are included in managed care

\*Data is gathered from the Client Service Database, which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being enrolled in a managed care plan counts as receiving medical services, regardless of whether the child visited a health professional or not.

Medically Eligible Title XIX description:

Clients who are eligible to receive medical services for which the state receives federal Title XIX

matching funds. Title XIX of the Social Security Act funds:

- (1) medical assistance on behalf of families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and of aged, blind, or disabled individuals.
- (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

**Narrative:**

In 2006, 88.0% of potentially Medicaid eligible children in Washington received a service paid for by the Medicaid Program. Data are gathered from the Washington State Department of Social and Health Services (DSHS) Client Services Database (CSDB) and the Office of Financial Management (OFM). Trends from 2000 to present have shown a slightly decreasing trend of about 1.0% per year.

***/2010/In 2007, 88.5% of potentially Medicaid eligible children in Washington received a service paid for by the Medicaid Program. Data are gathered from the DSHS Client Services Database (CSDB) and OFM. This year's data represent the second year in a row in which this indicator has increased following a number of years with a general downward trend./2010//***

OMCH collaborated with DSHS Health and Recovery Services Administration (DSHS-HRSA) to develop a plan to increase the quality of and access to the Early Periodic Screening Diagnosis and Treatment program (EPSDT.) EPSDT provides well-child check-ups for children ages birth to 18 years. EPSDT improvement workgroups have been established to develop strategies for three specific areas of EPSDT including: quality improvement; incentives for quality screen; health literacy and consumer education; and pilot projects. OMCH staff have partnered with DSHS-HRSA to lead and facilitate these workgroups. There may be increased work through EPSDT due to the Governor's focus on health insurance. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children to the newly expanded state subsidized insurance through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 53.9        | 56.5        | 57.0        | 59.1        | 60.3        |
| Numerator   | 72821       | 73259       | 76404       | 78397       | 81395       |
| Denominator   | 135052      | 129672      | 133948      | 132761      | 134958      |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final       |

**Notes - 2008**

These data come from the Washington State Department of Social and Health Services Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2008. The denominator represents the total

number of children ages 6-9 enrolled in Medicaid in 2008, in both Healthy Options (the MAA managed care program) and fee-for-service.

#### **Notes - 2007**

These data come from the Washington State Department of Social and Health Services Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2007. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2007, in both Healthy Options (the MAA managed care program) and fee-for-service.

These data are provisional.

#### **Notes - 2006**

These data come from the Washington State Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2006. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2006, in both Healthy Options (the MAA managed care program) and fee-for-service.

In 2006 the rate of EPSDT eligible children who received dental services during the year was 57.0 %, an increase over prior years, following a slightly increasing trend evident since 2000. These data are gathered from the DSHS Health and Recovery Services Administration (HRSA).

#### **Narrative:**

*/2010/In 2008 the rate of ESPDT eligible children who received dental services during the year was 60.3%, an increase over prior years, although only a slight increase over last year's rate of 59.1%. A general increase in this indicator has been evident since 2005 when a previous decreasing trend in the indicator, evidenced since 2000, was reversed. These data are gathered from the Washington State Department of Social and Health Services, Health and Recovery Services Administration (DSHS-HRSA). Data collection methodology has not been constant over the years; therefore caution should be taken when interpreting trends./2010//*

OMCH seeks to improve outcomes related to this measure through the following efforts: Kids Matter, a partnership and strategic plan/framework developed through the Early Childhood Comprehensive Systems (ECCS) grant, includes medical homes as one of the focus areas for promoting improvement and coordination in services for young children and their families. OMCH staff partner with other state agencies on an EPSDT Improvement Team to promote and improve access to and implementation of EPSDT across the state. The OMCH Oral Health Program promotes access to dental care for low income children.

The Oral Health Program provides funding to local health jurisdictions to conduct assessment for oral health capacity, develop partnerships to improve capacity, and provide linkage and referral for children to the Access to Baby and Child Dentistry (ABCD) program.

In the future, OMCH staff will continue to work with partners to develop new strategies through the Bright Futures Guidelines work, Kids Matter, and EPSDT Improvement Team. The Oral Health Program will continue to look for opportunities to promote access to dental care for low income populations.

*/2010/The Oral Health Program is developing new strategies by partnering with private and public organizations and individuals to develop the State Oral Health Plan./2010//*

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 7.7         | 6.1         | 5.9         | 5.5         | 5.4         |
| Numerator   | 910         | 875         | 897         | 860         | 749         |
| Denominator   | 11893       | 14300       | 15217       | 15720       | 13907       |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final       |

**Notes - 2008**

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2008. The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving SSI, 2008. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

**Notes - 2007**

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2007 (860). The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving SSI, 2007. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

**Notes - 2006**

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2006 (897). The denominator is from state-specific data from Children Receiving SSI, 2006. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

This data reflects children under the age of 18 instead of under the age of 16, because the SSI releases data with this cutoff. Therefore, any adjustment would only be a crude estimation.

**Narrative:**

These data are gathered from the State Children with Special Health Care Needs Program's (CSHCN) Child Health Intake Form (CHIF). This is a program enrollment form completed at local health jurisdictions and submitted to CSHCN quarterly. The number of state SSI beneficiaries who are less than 18 (SSA does not calculate data separately for < 16 year olds) years old is calculated from the annual Children Receiving SSI report produced by the Social Security Administration (SSA). Data from 2007 indicate that approximately 5.4% of State SSI beneficiaries received rehabilitative services from CSHCN, which is a decrease from the ten percent rate in

2003. Data collection methodology has not been constant in recent years, making rates erratic; therefore caution should be taken when interpreting trends.

In Washington State the CSHCN focus is in building systems of care, not providing or funding direct services. All children who are approved for SSI receive full Medicaid benefits. The benefits package provides unlimited therapies to children. The CSHCN program works closely with the state Medicaid agency to assure access to these services. Local CSHCN programs assist families in applying for appropriate benefits, including SSI and Medicaid. Our target is purposefully low to reflect the service system in the state. CSHCN continues to be involved with the Medicaid agency to provide input on policies and rules regarding benefits, billing and reimbursement. CSHCN created and continues to support a system of regular regional and statewide meetings to provide ongoing discussion regarding barriers and opportunities for children with special needs, including health coverage benefits. Regular attendees in these meetings include the state Medicaid agency, other state agencies, health plans, family organizations and a variety of providers.

**Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)***

| INDICATOR #05<br><i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i> | YEAR | DATA SOURCE         | POPULATION |              |     |
|--|------|---------------------|------------|--------------|-----|
|  |      |                     | MEDICAID   | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams)  | 2007 | matching data files | 6.7        | 5.9          | 6.3 |

**Narrative:**

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Washington State Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of low birthweight than do non-Medicaid recipients. However, since 1990 the Medicaid singleton low birthweight rate has remained stable, while the non-Medicaid singleton low birthweight rate has increased.

***/2010/First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS targets Medicaid eligible pregnant women who are at highest risk for low birth weight, to promote healthy birth outcomes. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010. The program will now focus on the highest risk women for low birth weight and infant mortality.***

***Unintended variations in the cesarean, vaginal birth after cesarean (VBAC), and induction rates are affecting maternal and infant health, including low birth weight. The Maternal and Infant Health (MIH) program and DSHS have co-convened a Perinatal Advisory Committee sub-committee to address these issues. This subcommittee meets monthly to review the literature for best practices and to make decisions about efforts to improve quality in maternity and infant care. They will ultimately make recommendations to community providers and agencies on how to improve safety, patient choices, and efficacy of C-sections and VBACs.***

**MIH has presented information on declining prenatal care access to several local community groups and the statewide Perinatal Advisory Committee. MIH has also worked with targeted communities to develop community level strategies for improving prenatal care access, particularly for Medicaid women. This includes working with the African American and Native American populations. MIH also provides information on our website regarding resources for women seeking prenatal care.**

**The Institute of Medicine (among others) recommends using preterm delivery in addition to birth weight to study prematurity. Every year in Washington State, about 3,300 babies are born preterm, but with normal birth weight. These babies are not included in prematurity statistics using only low birth weight as the measure. The DOH Center for Health Statistics is doing a study to see how the calculated and estimated gestational ages compare to each other and how they relate to other birth certificate data and hospitalization data.//2010//**

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs. non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through workgroups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. The PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

#### **Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births**

| <b>INDICATOR #05<br/>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b> | <b>YEAR</b> | <b>DATA SOURCE</b>  | <b>POPULATION</b> |                     |            |
|---|-------------|---------------------|-------------------|---------------------|------------|
|   |             |                     | <b>MEDICAID</b>   | <b>NON-MEDICAID</b> | <b>ALL</b> |
| Infant deaths per 1,000 live births   | 2006        | matching data files | 5.9               | 3.7                 | 4.7        |

#### **Notes - 2010**

The overall number for this HSCI differs from the calendar year 2007 period infant mortality rate for outcome measure 01. Outcome measure 01 is a period mortality rate and reflects the total number of infant deaths during calendar year 2007 divided by the total number of live births in calendar year 2007.

**Narrative:**

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of infant deaths than do non-Medicaid recipients. While both rates have declined since 1990, the mortality rate of infants whose mothers received Medicaid experienced a greater decline.

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs. non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by Maternal and Infant Health (MIH), meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through workgroups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

***/2010/MCH Assessment continues to update the Perinatal Indicators Report which also includes infant mortality comparisons by Medicaid/non-Medicaid status. In 2006, the mortality of infants whose mothers received Medicaid-funded maternity care (5.9 per 1,000) continued to exceed the mortality of infants whose mothers did not receive Medicaid-funded maternity care (3.7 per 1,000). While both rates have declined since 1990, the mortality rate of infants whose mothers received Medicaid experienced a greater decline./2010//***

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| INDICATOR #05<br><i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the</i> | YEAR | DATA SOURCE | POPULATION |              |     |
|--|------|-------------|------------|--------------|-----|
|  |      |             | MEDICAID   | NON-MEDICAID | ALL |
|  |      |             |            |              |     |

| State  |      |                     |      |      |      |
|--|------|---------------------|------|------|------|
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2007 | matching data files | 65.3 | 86.6 | 76.4 |

**Notes - 2010**

These data come from a different source than do those reported in NPM18.

**Narrative:**

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Washington State Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients are less likely to receive first trimester prenatal care than non-Medicaid recipients.

*/2010/First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS provides services to promote early and continuous prenatal care for Medicaid eligible pregnant women. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.*

*Prenatal care utilization data was monitored, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. Overall in Washington State, there appeared to be a downward trend in first trimester care beginning in 2003, especially for low-income women and in specific localities. The disparity in first trimester prenatal care access between Medicaid and Non-Medicaid women appeared significant. In 2003, Washington State was one of the first states to use the new birth certificate. With 20% missing data for entry into prenatal care the first couple of years, and only 3 data points, we were not ready to declare a trend.*

*The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 76.4% in 2007. In other words, the number of women in Washington entering prenatal care in the first trimester has decreased by almost 5 percentage points in the past four years, with a larger decrease among Medicaid women. However, in the same timeframe the percentage of women entering prenatal care in the 2nd and 3rd trimesters have both increased, thus indicating a gradual shifting into care later in the pregnancy.*

*The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. During this period 6,593 pregnant women called the FHH. Of these callers, 1,735 were already receiving prenatal care.*

*In Pierce County, a contractor provided outreach to African American women to encourage early entry into prenatal care and enrollment in MSS by attending community events, church sponsored events, and other community meetings. Results from these efforts included an increased presence and partnership with the African American community in Pierce County. Feedback from community members led to piloting a new way to work with this community./2010//*

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs. non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by Maternal and Infant Health (MIH), meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through workgroups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

***//2010/MIH has presented information on declining prenatal care access to several local community groups and the statewide PAC. MIH has also worked with targeted communities to develop community level strategies for improving prenatal care access, particularly for Medicaid women. This includes working with the African American and Native American populations. MIH also provides information on our website regarding resources for women seeking prenatal care.//2010//***

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| INDICATOR #05<br><i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>        | YEAR | DATA SOURCE         | POPULATION |              |      |
|---|------|---------------------|------------|--------------|------|
|   |      |                     | MEDICAID   | NON-MEDICAID | ALL  |
| Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2007 | matching data files | 57.8       | 71.1         | 64.8 |

**Notes - 2010**

These data come from a different source than do those reported in HSCI04.

**Narrative:**

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Washington State Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement

strategies for improvement where indicated.

One major health indicator tracked by OMCH is the percent of pregnant women with adequate prenatal care (observed or expected prenatal visits are greater than or equal to 80% of the Kotelchuck index): These data show that Medicaid recipients are less likely to receive adequate prenatal care (based on Kotelchuck index), than non-Medicaid recipients. OMCH's efforts to improve this indicator include First Steps Maternity Support Services (MSS) activities and data monitoring, analysis, and publication. Maternal and Infant Health (MIH) also worked with specific communities where the disparity between Medicaid and non-Medicaid first trimester entry into prenatal care was greater than the state average. We are identifying specific systems barriers in an effort to problem-solve. In addition, MIH has attempted to improve the quality and completeness of birth certificate filing data to improve our ability to assess prenatal care entry and adequacy. This was done through a state-wide quality improvement project in which contractors worked with targeted hospitals to increase the completeness of the prenatal data on the birth filing record, specifically targeting the date of first prenatal care, pre-pregnancy height and weight, and date of last menses.

***//2010/MSS providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS provides services to promote early and continuous prenatal care for Medicaid eligible pregnant women. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.***

***The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. During this period 6,593 pregnant women called FHH. Of these callers, 1,735 were already receiving prenatal care. A total of 7,800 related referrals were given to these callers.***

***MIH has presented information on declining prenatal care access to several local community groups and the statewide Perinatal Advisory Committee. MIH has also worked with targeted communities to develop community level strategies for improving prenatal care access, particularly for Medicaid women. This includes working with the African American and Native American population. MIH also provides information on our website regarding resources for women seeking prenatal care.//2010//***

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs. non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through workgroups that address perinatal issues, including services and

outcomes for Medicaid and non-Medicaid women and their newborns. PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b> | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL Medicaid</b> |
|---|-------------|--|
| Infants (0 to 1)  | 2007        | 200                                      |
| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>    | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL SCHIP</b>    |
| Infants (0 to 1)  | 2007        | 300                                      |

**Narrative:**

These data come from Washington State Department of Social and Health Services (DSHS).

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

*/2010/The First Steps program will focus on referring Medicaid eligible infants to the newly formed Apple Health Program, which is the Washington State SCHIP.*

*WithinReach's Family Health Hotline (FHH) and Apple Health for Kids Hotline (formerly HealthyKidsNow!) referred families with children to benefit programs including Medicaid and SCHIP and provided information about children's health and services for children. During this period 11,249 callers with children called FHH and 7,922 called the Apple Health for Kids Hotline./2010/*

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b> | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL Medicaid</b> |
|---|-------------|--|
| Medicaid Children<br>(Age range 1 to 18)<br>(Age range to )<br>(Age range to )  | 2007        | 200                                      |
| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>    | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL SCHIP</b>    |
| Medicaid Children<br>(Age range 1 to 18)  | 2007        | 300                                      |

|                 |  |  |
|-----------------|--|--|
| (Age range to ) |  |  |
| (Age range to ) |  |  |

**Narrative:**

These data come from Washington State Department of Social and Health Services (DSHS).

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

***/2010/WithinReach 's Family Health Hotline (FHH) and Apple Health for Kids Hotline referred families with children to benefit programs including Medicaid and SCHIP and provided information about children's health and services for children. During this period 11,249 callers with children called FHH./2010//***

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b> | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL Medicaid</b> |
|---|-------------|--|
| Pregnant Women  | 2007        | 185                                      |
| <b>INDICATOR #06</b><br><b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>    | <b>YEAR</b> | <b>PERCENT OF POVERTY LEVEL SCHIP</b>    |
| Pregnant Women  | 2007        |  |

**Notes - 2010**

SCHIP eligibility applies to children only.

**Narrative:**

These data come from Washington State Department of Social and Health Services (DSHS).

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

***/2010/SCHIP is used to cover expenses of some pregnant women in Washington State and FPL is 185%, which is consistent with Washington State's eligibility criteria for Medicaid services for pregnant women./2010//***

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| <b>DATABASES OR SURVEYS</b>  | <b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b> | <b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b> |
|--|---|---|
| <u>ANNUAL DATA LINKAGES</u><br>Annual linkage of infant birth and infant death certificates        | 3   | Yes   |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files                 | 3   | No  |
| Annual linkage of birth certificates and WIC eligibility files                                     | 2   | No  |
| Annual linkage of birth certificates and newborn screening files                                   | 3   | Yes   |
| <u>REGISTRIES AND SURVEYS</u><br>Hospital discharge survey for at least 90% of in-State discharges | 3   | Yes   |
| Annual birth defects surveillance system   | 3   | Yes   |
| Survey of recent mothers at least every two years (like PRAMS)                                     | 3   | Yes   |

**Notes - 2010**

**Narrative:**

Access to data from other programs and agencies is built from gaining the trust from these programs and agencies. OMCH, especially MCH Assessment, works to gain and maintain that trust. MCH Assessment maintains access to analytic data files and up-to-date documentation for: vital statistics, hospital discharge data, linked vital statistics and hospital discharge data, Pregnancy Risk Assessment Monitoring System data, Healthy Youth Survey, Behavioral Risk Factor Surveillance data, National Immunization Survey, National Survey of Children's Health, National Survey of Children with Special Needs, and in-house survey data. These data are used extensively for reports and presentations within OMCH, DOH and with external stakeholders to promote the use of data to inform policy discussions and program planning. In addition, the MCH Assessment manager participates on the Assessment Operations Group which is a cross-agency group dedicated to communication among epidemiologists and assessment staff across the DOH. The group meets monthly and discusses analytic guidelines, methodology, surveys in the field, data-sharing, ethics, confidentiality, data security and IRB-related concerns, and potential collaborations.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| <b>DATA SOURCES</b>               | <b>Does your state participate in the YRBS survey?<br/>(Select 1 - 3)</b> | <b>Does your MCH program have direct access to the state YRBS database for analysis?<br/>(Select Y/N)</b> |
|-----------------------------------|---|---|
| Youth Risk Behavior Survey (YRBS) | 1   | No  |
| Health Youth Survey               | 3   | Yes   |

**Notes - 2010**

**Narrative:**

There are two major factors that influence the OMCH's ability to maintain and/or improve this indicator. First, the Tobacco Settlement Fund has been critical to Washington's ability to capture data on smoking behaviors among school students. Every two years, Washington conducts the Healthy Youth Survey (HYS), which gathers information about behaviors among public school students. The Tobacco Settlement Fund contributes almost two thirds of the operational costs of the survey. Second, the HYS is led by a multi-agency workgroup. OMCH works with other state agencies and partners to develop questions for the HYS. The ability of this workgroup to resolve issues that cross agency boundaries has been instrumental in the on-going political support the survey has maintained.

*/2010/DOH's tobacco prevention funds were cut more than 40% during the most recent legislative session. The tobacco program was one of the chief sources of funding for the Healthy Youth Survey (HYS), the principle manner in which the State of Washington collects data on its adolescent population regarding a variety of health behaviors. The HYS has been given every other year to students in the 6th, 8th, 10th, and 12th grades. As a result of the cuts, it is likely that the HYS will discontinue the 12th grade portion of the survey. This would prevent data collection on 12th grade behaviors, including tobacco use./2010//*

## IV. Priorities, Performance and Program Activities

### A. Background and Overview

During the 2005 5-year Needs Assessment the office worked with partners throughout the state to identify nine priorities. In 2006-07, the office continued to consult with its partners and refine the priorities. Briefly, the changes involved merging two related priorities into one comprehensive priority and creating a new priority related to promoting health equity. Issue briefs were developed for each priority to clearly state the focus, objective, and expectations for setting each priority. The current list of MCH priorities is reflected in Form 14. See Section IIC for an updated Needs Assessment Summary about how the priorities are used to guide and describe the work of the Office of Maternal and Child Health (OMCH).

The 5-year needs assessment completed in 2005 was coordinated with the development of a 5-year organizational and performance plan. The needs assessment describes the process and the products generated during this assessment and planning period. It includes population priorities, performance measures, activities, and outcome measures. The 5-year organizational and performance plan includes an assessment of the work we do and how we do it in relation to the 9 priorities developed through the 5-year needs assessment. One result of these efforts was being able to contribute to the Community and Family Health (CFH) Division's 2-Year Strategic Plan. The 2005 Needs Assessment process and resulting MCH priorities helped shape the CFH Strategic Plan and served as the basis for developing the Division's priorities.

The 5-year needs assessment included stakeholder involvement, data collection and analysis, and a thorough review of program activities to redefine the priorities for the MCH population in Washington State. The priorities developed through the 2005 needs assessment process are very similar to those developed in the 2000 needs assessment; however, they are more universal and address the needs across the MCH population rather than specific groups within the MCH population. The 2005-09 priorities represent our goals for sustaining and improving the health of women, infants, children, adolescents, and their families. The needs assessment process served to reaffirm that Washington's MCH programs are appropriately focusing resources on the most pressing needs of the MCH population in the state.

In most cases, the needs reflected in the 2005-09 priorities are more pronounced than they were in previous years due to significant reductions, and in some cases complete elimination, of program funding at the federal and state levels, and increased economic hardship statewide. Maternal and child health programs throughout the state continue to face financial challenges. The MCH priority outcomes developed through the 2005 Needs Assessment help guide discussions and ultimately decisions about budget cuts and program alignment with state and national performance measures. MCH Block Grant reductions most significantly affect National Performance Measures 1, 3, and 4 and State Performance Measure 5. Results of budget cuts are described in the performance measure narratives.

Detailed descriptions of OMCH's work on the national and state performance measures are provided in this section under items, C. National Performance Measures, and D. State Performance Measures. Three new state performance measures are introduced in the 2009 application and 2007 annual report. The new measures represent process measures that will, over time, lead to the development of outcome measures. The new outcome measures will be aligned with the MCH priorities and will measure the collective efforts of multiple sections in the office.

***//2010/Work on the 2010 Needs Assessment has already started. OMCH has worked with partners to identify the process we will use. We anticipate that the current broad priorities will not need to be changed significantly. However, we plan on identifying specific priority activity areas (sub-priorities) that the office will focus more attention on in the future.//2010//***

## **B. State Priorities**

### 2005 - 2009 OMCH Priorities

As part of the 2005 Five Year Needs Assessment, OMCH developed nine priorities. A crosswalk between the 2000 -2004 priorities and the 2005 -2009 priorities and a crosswalk between the old state performance measures and the new state performance measures are included with the 2006 Application and 2004 Annual Report.

The following summarizes the relationship between Washington State's OMCH priorities and the state performance measures, national performance measures, outcome measures, and health systems capacity indicators.

//2009/This crosswalk tool was updated for the 2009 block grant application and 2006 annual report to reflect the removal of some state performance measures and the addition of new ones.//2009//

#### Adequate nutrition and physical activity

NPM 11, 15

OM 1-5 SPM07

HSCI 5, 9a

HSI 1a-b, 2a-b

#### Lifestyles free of substance use and addiction

NPM 10, 15

OM 1-5

SPM 08

HSCI 1, 9b

HSI 1a-b, 2a-b, 3a-c, 4a-c

#### Optimal mental health and healthy relationships

NPM02, 6, 11, 16

OM 6

SPM 09

HSCI 4

#### Safe and healthy communities

HSCI 1

NPM 10, 16

OM 6

SPM 08, 9

HSI 3a-c, 4a-c

#### Health Equity

OM 2

SPM 10

#### Healthy physical growth and cognitive development

NPM 06, 11, 12

SPM 07, 8, 9,

#### Sexually responsible and healthy adolescents and women

NPM 08, 18

SPM 01, 8, 9

HSCI 4

HSI 5a-b

Access to preventive and treatment services for the MCH population

NPM 03-7, 9, 12-14, 17-18

OM 1-5

SPM 01, 6, 7, 10

HSCI 3-8

Quality Screening, identification, intervention, and care coordination for the MCH population

NPM 1-3, 5-7, 9, 12, 17, 18

OM 1-5

SPM 06, 8, 10

HSCI 2-5, 7

### C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>    |
|---|-------------|-------------|-------------|-------------|----------------|
| Annual Performance Objective  | 99.7        | 95          | 100         | 100         | 100            |
| Annual Indicator  | 100.0       | 100.0       | 98.9        | 100.0       |                |
| Numerator   | 88          | 99          | 91          | 89          |                |
| Denominator   | 88          | 99          | 92          | 89          |                |
| Data Source   |             |             |             |             | See field note |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>    |
| Annual Performance Objective  | 100         | 100         | 100         | 100         | 100            |

#### Notes - 2008

Data are not available.

#### Notes - 2007

PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2008-2013, the future objectives will be 100%.

The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, hemoglobinopathies, and congenital adrenal hyperplasia with appropriate referral. Over time laboratory cutoffs have been adjusted for some conditions to decrease the detection of infants with conditions that are NOT clinically significant and don't require treatment.

These data come from Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that

received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2007, 99.2% of newborns received a newborn screening ( 84,925 of 85,641). Excluded from the denominator were births in military hospitals (3,077), refusals (48), neo-natal deaths (157) and a small number tested by the State of Oregon (21). Washington State currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), homocystinuria and Cystic Fibrosis. See Form 6 for details on conditions.

#### **Notes - 2006**

**PERFORMANCE OBJECTIVES:** The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2007-2012, the future objectives will be 100%.

The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, hemoglobinopathies, and congenital adrenal hyperplasia with appropriate referral. Over time laboratory cutoffs have been adjusted for some conditions to decrease the detection of infants with conditions that are NOT clinically significant and don't require treatment.

These data come from Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2006, 99% of newborns received a newborn screening. The state currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), homocystinuria and Cystic Fibrosis. See Form 6 for details on conditions.

#### **a. Last Year's Accomplishments**

The Newborn Screening Program (NBS) tested over 99% of infants born in Washington State (with the exception of those born at the three military hospitals) for 25 treatable disorders. Fifteen of these disorders were added to the screening panel in 2008. The State Board of Health's (SBOH) criteria for adding new conditions include: 1) Prevention potential and medical rationale; 2) Availability of treatment; 3) Public health rationale and; 4) availability of suitable screening technology. A cost benefit analysis is also done on each condition.

In calendar year 2008 we screened 166,000 specimens from 83,000 infants. The results of these screenings were: Biotinidase deficiency (0); Congenital adrenal hyperplasia (8); Congenital hypothyroidism (81); Cystic fibrosis (15); Galactosemia (2); Hemoglobinopathies (16); Amino acid disorders (8, 6 PKU, 2 MSUD); Organic disorders (0); Fatty acid oxidation disorders (135). In addition, we identified 1,418 infants with hemoglobin patterns that are not clinically significant (for example, sickle cell trait, which was found in 509 infants.)

NBS administered laboratory and follow-up services necessary for a complete newborn screening system. These included monitoring birth records to assess the completeness of screening, laboratory testing, advising health care providers about appropriate diagnostic and treatment follow-up, evaluating short and long term outcomes, and providing communication and education about the program. Appropriate follow up of abnormal screening results facilitated prompt diagnosis and appropriate treatment for all screen positive infants.

NBS initiated a bi-weekly conference call with clinical partners at University of Washington (UW) and Seattle Children's (SC) Biochemical Genetics Clinic and Laboratory. The calls allow us to track and coordinate our responses to children who have screened positive for the large number of biochemical disorders we added to the screening panel in 2004 and 2008. These calls help improve coordination of services.

We partnered in the Northwest Sickle Cell Collaborative (NWSCC) to expand services to children with sickle cell disease and other hemoglobinopathies. We helped develop an outreach program

offering hemoglobin trait screening for adults. The program uses dried blood spot filter paper collection, avoiding the need for a venous blood draw, reducing the cost and potential psychological stress. We analyze the specimens using our protocols developed for newborn screening. Testing costs are reimbursed by NWSCC. NWSCC is overseen by the Odessa Brown Sickle Cell Clinic and funded through a federal Health Resources and Services Administration (HRSA) grant.

NBS continued to collaborate with researchers from the Pacific Northwest Research Institute (PNRI) to investigate type1 diabetes through The Environmental Determinates of Diabetes in the Young (TEDDY) study. This study is funded through a National Institutes of Health (NIH) grant as part of a large multi-center, multi-national prospective study to look for environmental triggers of type 1 diabetes. Research staff stationed at selected hospitals recruited participants from newborns who have high-risk genetic profiles. If parents consented to participate in the study, we provided the researchers a small sample of leftover blood from the child's newborn screening specimen. This was screened for genetic markers that indicate an increased risk of developing type 1 diabetes. If these markers are found, families are offered periodic screening for antibodies that signify potential onset of the disease. Early detection of type 1 diabetes onset can prevent significant hyperglycemia.

When the recruitment phase of TEDDY ends in late 2009, TEDDY hospitals will be asked to join the DEWIT 2 study. Families whose infants are found to be at increased risk through TEDDY will be invited to participate in a second part of the study, which will track a number of environmental variables and antibody measurements until the child reaches the early teens.

We collaborate with UW, SC, and Fred Hutchinson Medical Center to look at the relationship between cytomegalovirus in an infant's blood and development of hearing loss. This is a case control study with cases solicited from SCH Hearing Clinic. With parent's informed consent, we provide investigators with a sample from the left over newborn screening specimen, along with a sample from an anonymous specimen of similar age and sex to serve as a control.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Ensure that all screen positive infants receive timely diagnosis and, if needed, are enrolled in long-term clinical management.  |                          |    |     | X  |
| 2. Perform screening tests for all mandated conditions on approximately 170,000 specimens.  |                          |    | X   |    |
| 3. Follow-up to assure that appropriate diagnostic and clinical services are provided in response to screening test results.  |                          |    | X   |    |
| 4. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.                          |                          |    |     | X  |
| 5. Update and develop new professional and lay educational information for distribution: Websites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc. |                          |    |     | X  |
| 6. Determine family eligibility for financial and support services and coordinate through state and county Children with Special Health Care Needs programs (CSHCN) and medical homes.          |                          | X  |     |    |
| 7. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.   |                          | X  |     |    |
| 8. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.   |                          |    |     | X  |
| 9. Continue to work with researchers to evaluate potential  |                          |    |     | X  |

|  |  |  |  |  |
|--|--|--|--|--|
| screening tests for other treatable childhood disorders; currently Type 1 Diabetes, lysosomal storage diseases, and cytomegalovirus (CMV) infection. |  |  |  |  |
| 10.  |  |  |  |  |

#### **b. Current Activities**

NBS ensures that all screen positive infants receive timely diagnosis and are enrolled in clinical management as needed. One child with a severe form of maple syrup urine disease was born out of hospital and not screened. The child was hospitalized when symptoms appeared and died shortly after a specimen was collected.

NBS works with UW Biochemical Clinic to evaluate an approach to detecting lysosomal storage diseases in infants through newborn screening. This work is supported by a grant from NIH. It will use anonymous specimens that are residual to required screening. The study will focus on one of the lysosomal storage diseases, Fabry, and plans to expand to include Pompe, and mucopolysaccharidosis type 1. The protocol will involve screening the residual specimens and submitting positive samples to UW for genetic testing for the disease.

We initiated collaboration with the Pacific Northwest Diabetes Research Institute (PNDRI) to implement, DEWIT 2, a project funded by the State's Life Sciences Discovery Fund. DEWIT 2, uses the same genetic screening approach as TEDDY. Participants are recruited through pamphlets given to parents at the hospital of birth. They describe the study and include instructions on joining and an informed consent form. We also continue to collaborate with the PNDRI on TEDDY.

We continue collaboration with UW, SC, and Fred Hutchinson Medical Center to look at the relationship between cytomegalovirus in an infant's blood and development of hearing loss.

#### **c. Plan for the Coming Year**

NBS will continue to work with our partners at Seattle Children's and the University of Washington to review and revise our algorithms for evaluating screening test results for the 15 disorders that were added in 2008. We will work to achieve a balance of sensitivity and specificity and, where possible, minimize the impact on families when results fall into grey zones.

NBS will keep abreast of the growing knowledge and developments in the research and clinical realms of expanded newborn screening. There is a large knowledge gap related to the recent expansion of disorders screened in the areas of diagnostic confirmation, including prediction of phenotype, and best practices for short and long term treatment. There is also a poor understanding of the natural history of many of the conditions currently detected through screening.

NBS will continue to support the activities of the Northwest Sickle Cell Collaborative through a contract currently funded by state funds. Oversight will be provided by the Odessa Brown Sickle Cell Clinic to meet the objectives of a legislative proviso to promote awareness of sickle cell disease, provide nurse and physician training and education, and conduct community outreach and sickle cell trait testing. We are hoping to be awarded a CDC grant to develop and implement population-based surveillance for hemoglobinopathies to lay a solid foundation for future hemoglobinopathy registries.

NBS will partner with the Hawai'i Genetics Program (part of the Western States Collaborative) on a HRSA-funded research project titled Newborn Screening Results Project: Financial, Ethical, Legal and Social Issues (Key Informant Issues with Parents, Physicians, and Newborn Screening Programs). The purpose of the study is to assess satisfaction with 1) the way in which newborn screening results are communicated/provided, and 2) the educational materials that are provided/available.

NBS will continue collaboration with 1) the Life Sciences Discovery Fund for the DEWIT 2 project, which offers parents an opportunity to have their newborn screened for genetic markers that indicate an increased risk of developing Type-1 diabetes, and 2) the UW grant for developing an efficacious screening method for Lysosomal Storage Diseases.

NBS will consider participating in a proposed research study with UW's Epidemiology Department. This study proposes to look at correlations between the mother's smoking level as reported on the birth certificate and levels of cotinine (a nicotine metabolite) in dried blood spots. We may also consider possible collaboration with the University of Minnesota on the same or a related project.

NBS considers supporting and participating in well designed research proposals that promise to improve health, particularly child health.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>              |
|---|-------------|-------------|-------------|-------------|--------------------------|
| Annual Performance Objective  | 54.9        | 56          | 56.5        | 57          | 55.7                     |
| Annual Indicator  | 54.9        | 54.9        | 54.9        | 55.7        | 55.7                     |
| Numerator   |             |             |             |             |                          |
| Denominator   |             |             |             |             |                          |
| Data Source   |             |             |             |             | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                          |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>              |
| Annual Performance Objective  | 55.7        | 55.7        | 55.7        | 55.7        | 55.7                     |

#### Notes - 2008

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate. In 2007, following the release of the most recent survey, discussions with program staff led to the target of 55.7% to be established through 2013.

Data come from survey and state numerator/denominator are not available

#### Notes - 2007

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate.

## Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.5% was chosen through 2012.

### a. Last Year's Accomplishments

Family advisors were involved in Children with Special Health Care Needs (CSHCN) regional meetings, Medical Home Leadership Network (MHLN) teams, Communication Network, Family To Family Health Information Center, MCH Block Grant training, Washington Family to Family Network, Medical Home strategic planning and other activities, Association of Maternal and Child Health Programs (AMCHP), MCH Region X, and Family Voices Region X. The epilepsy and oral health grants, and the Effective Presentations: Teaching Through Stories curriculum provided new ways for families to be involved. Additionally family leaders assisted in determining how to select activities to improve Washington State's National Performance Measures.

Effective Presentations: Teaching Through Stories, a family leadership training curriculum was conducted through a contract with Seattle Children's. This trained two parent groups to become trainers and use the curriculum in their communities. A presentation of the curriculum was offered at the annual AMCHP meeting in Washington DC.

The Autism Task Force continued through June 2008. Parents provided input for a legislatively mandated guidebook. This guidebook was completed by the Autism Task Force with support from CSHCN. CSHCN received a Combating Autism State Implementation grant from the federal Health Resources Services Administration (HRSA). CSHCN formed the Combating Autism Advisory Council (CAAC) which includes representatives, including parents, from other states as well as Washington. CAAC guides the activities of this grant.

Parents of children with epilepsy and seizure disorders participated in focus groups and support groups, provided input for grant activities, and are adopting the use of care organizers to keep track of their children's health information.

Parents and caregivers participated in two regional meetings and provided their experiences and perspectives on oral health for special populations. CSHCN provided a stipend and travel costs to participants. The information we gathered was used to guide the work of the Oral Health Project for children with special health care needs.

We supported community-based feeding teams, which include parents as members, through a contract with the University of Washington (UW).

The WE CAN Partnership's grant proposal to enhance the development of Medical Home family-professional partnerships at the community level, was submitted to MCHB but not funded.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources. |                          |    |     | X  |
| 2. Ensure family representation in policy development through Medical Home Leadership Network, local health jurisdictions, Autism and Epilepsy projects, Washington Family to Family   |                          |    |     | X  |

|  |  |  |  |  |
|--|--|--|--|--|
| Network partnership and ongoing dialogue at CSHCN Communication Net. |  |  |  |  |
| 3.   |  |  |  |  |
| 4.   |  |  |  |  |
| 5.   |  |  |  |  |
| 6.   |  |  |  |  |
| 7.   |  |  |  |  |
| 8.   |  |  |  |  |
| 9.   |  |  |  |  |
| 10.  |  |  |  |  |

#### **b. Current Activities**

MCH Family and Consumer Involvement Survey results are being used to create a plan for improving methods across OMCH to support family and consumer involvement.

The Epilepsy and Autism projects are recruiting parents, providers, and other professionals to attend state and national learning collaborative meetings and summits to learn and share ideas. A fulltime Family Involvement Coordinator is on staff to provide leadership. Parent-professional partnerships are supported through contracts with the UW Medical Home Leadership Network, Parent to Parent, Fathers Network, Nutrition contracts and local health jurisdictions. Local CSHCN Coordinators link families to appropriate information and referral services in their communities.

Family advisors and partners participate in CSHCN Communication Network meetings, MCH Block Grant trainings, MCH Region X, and AMCHP, including the Family and Youth Partnership Committee. CSHCN supports Title V family leadership training, family advocacy and support resources, and family consultant tips and tools for parents and youth.

Coaching resources for parents are being identified to help parents participate in community forums and medical home teams. The Family as Advisors Toolkit is being updated. A fact sheet on Family-Professional Partnerships has been created.

CSHCN works with the Oral Health program to conduct an oral health parent focus group.

#### **c. Plan for the Coming Year**

CSHCN will continue to partner with Parent to Parent, the Father's Network, and WithinReach through contract activities to ensure family representation throughout the state. CSHCN will increase collaboration with the Family to Family Health Information Center by attending Health Navigator trainings and helping families access support for their children's services.

Input obtained through MCH Block Grant training and review sessions, Medical Home Leadership Network team parents, epilepsy and oral health grant parent and youth advisors, and Washington Family to Family Network, will be reviewed and used as appropriate to update and enhance the Families as Decision Makers/Family Professional Partnership Strategic Plan.

A review of three leadership curricula will be conducted through a contract with Seattle Children's to determine the most effective materials for CSHCN's federal epilepsy and autism grants.

CSHCN will continue to promote family-professional partnerships to ensure that families participate as partners in decision-making with professionals at all levels in their child's care, and that families are satisfied with all health services that their children receive.

We will develop two training summits with input and participation from youth and parent advocates and develop material and trainings for culturally diverse parents of children with

autism. We will look for opportunities to market and promote CSHCN work products including the Autism Task Force Autism Family Guidebook, recently developed care coordination tools, and newly translated Medical Home brochures.

CSHCN will promote a recently completed DVD that tells the stories of three Hispanic families with children with special health care needs. The DVD is in Spanish with English subtitles. It will increase awareness of cultural diversity in family perspectives and care.

Existing family consultant tips and tools will be consolidated into a revised family advisor training toolkit for use by Washington State family advisors.

Parents of children with epilepsy will continue participating in the National Learning Collaborative and reviewing education and promotional materials. Both parents and youth will continue participating in support activities.

The autism grant will continue to include parents to guide grant activities. We will focus on our partnership with UW Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. We will assist them in developing their family faculty and encourage their involvement with CAAC. CAAC parent subcommittee is working on cultural diversity access issues for parents of children with autism.

The CSHCN section will continue to work with the Oral Health Program to involve parents in improving access to oral health care for CSHCN.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data   | 2004 | 2005 | 2006 | 2007  | 2008                     |
|---|------|------|------|-------|--------------------------|
| Annual Performance Objective  | 53.6 | 53   | 53   | 53    | 48.6                     |
| Annual Indicator  | 53.6 | 53.6 | 53.6 | 48.3  | 48.3                     |
| Numerator   |      |      |      |       |                          |
| Denominator   |      |      |      |       |                          |
| Data Source   |      |      |      |       | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |      |      |      |       |                          |
| Is the Data Provisional or Final?   |      |      |      | Final | Final                    |
|   | 2009 | 2010 | 2011 | 2012  | 2013                     |
| Annual Performance Objective  | 48.7 | 48.8 | 48.9 | 49    | 49.1                     |

#### Notes - 2008

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed in 2007 based on discussion with program staff. An annual increase of 0.1% was chosen, and has been extended through 2013.

**Notes - 2007**

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed based on discussion with program staff. An annual increase of 0.1% was chosen through 2012.

**Notes - 2006**

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.1% was chosen through 2012.

**a. Last Year's Accomplishments**

MCH Assessment and Children with Special Health Care Needs (CSHCN) reviewed data of the National Survey of Children with Special Health Care Needs (NS-CSHCN, 2005-06) for information to support program activities.

CSHCN continued to support the interagency DOH Medical Home Partnership Committee and saw an explosion in activities across diverse groups to promote medical homes for all children and adults.

CSHCN contracted with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities. This included providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes and participating in the Medical Home Leadership Network (MHLN). Currently, there are 18 MHLN teams statewide.

CSHCN and Medical Home contractors participated as planning members and team leaders for statewide Learning Collaborative on medical homes.

CSHCN completed and distributed a family directed brochure on medical homes. A small grant was received which allowed us to translate the new brochure and several other family directed materials on medical homes into multiple languages and have them posted on the MHLN website.

CSHCN worked with MCH Assessment to provide, analyze, and share data, including the Medical Home Data Monograph, at stakeholder meetings.

The CSHCN Nursing Consultant had discussions with Coordinators in each CSHCN Region on medical home promotion and participation. Maxillofacial Review Boards were encouraged to connect the children they serve to a medical home.

CSHCN worked with state agency partners to implement the 2007 legislation to extend Medicaid and other publicly-funded coverage for children and connect them to medical homes. CSHCN assisted with outreach to develop performance measures about medical home.

CSHCN Family Involvement Coordinator worked with Medical Home to increase family-professional partnerships at the local practice level.

Kids Matter continued to promote Medical Home as one of their strategies to enhance access to health care.

The Epilepsy project promoted the concept of medical home with families, providers, and care coordinators participating in grant activities. The University of Washington (UW) Regional Epilepsy Center worked to ensure that children with epilepsy who attended their clinic have an identified medical home.

Through a contract with UW, CSHCN Nutrition Network dietitians have integrated training and activities with MHLN.

CSHCN and the Oral Health program introduced and promoted Medical Home concepts to dental providers.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources. |                          |    |     | X  |
| 2. Contract with the Medical Home Leadership Network to support the Medical Home website, increase awareness of medical homes statewide and build the Medical Home Leadership Network.   |                          |    |     | X  |
| 3. Contract with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities.   |                          | X  |     |    |
| 4. Provide leadership to spread the medical home concept through strategic planning.   |                          | X  |     |    |
| 5. Implement the Epilepsy/Autism/Early Childhood Comprehensive Systems Grants to promote medical homes for children and youth with epilepsy.   |                          |    |     | X  |
| 6.   |                          |    |     |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

CSHCN provides leadership to spread the medical home concept through strategic planning, grant activities, and work on committees to improve reimbursement for activities related to medical homes and care coordination. CSHCN leads the DOH Medical Home Partnership Committee, a forum for other state agencies and private entities to share statewide activities related to medical home.

The Epilepsy and Autism projects promote medical homes through care coordination and co-management strategies, education, use of care notebooks and care plan tools, and other resources.

CSHCN nurtures partnerships through contracts with UW's Medical Home and Adolescent Health Transition Projects, the Center for Children with Special Needs at Seattle Children's, parent support organizations, nutrition projects and other partners to develop and maintain websites and resources related to medical homes.

CSHCN works with the local health jurisdictions to promote CSHCN Coordinators' involvement in

medical homes in their communities.

CSHCN supports broader agency legislation to promote medical homes for all kids and improve reimbursement for components of care within a medical home.

CSHCN Family Involvement Coordinator continues to work with Medical Home to increase family-professional partnerships.

### **c. Plan for the Coming Year**

CSHCN will work with developmental pediatricians and other state agencies to improve developmental screening in medical homes. An issue brief to promote routine developmental screening will be completed. CSHCN will also provide leadership on medical homes for children with special health care needs to the DOH medical home learning collaborative.

CSHCN will contract with the UW to strengthen family representatives in their role on the Medical Home Leadership Network teams, identify areas where they would like technical assistance, problem solve and share successful strategies with each other, and provide family input to the MHLN project. This contract will also work with Parent to Parent, Fathers Network and other family organizations to identify local parents interested in collaborating with MHLN teams to expand their autism activities.

CSHCN will continue to contract with UW Center on Human Development and Disability to promote and nurture the Medical Home Leadership Network and the development of Child Health Notes, a tool for providers to help them become a medical home by providing information on children with special needs.

CSHCN will continue to contract with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities. This includes providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes and participating on medical homes as part of the MHLN.

CSHCN will revise the Medical Home Strategic Plan to incorporate elements of the autism and epilepsy grants, assuring all children are connected to a medical home. We will continue to lead the DOH Medical Home Partnership Committee and share statewide activities about medical homes to interested partners.

A medical home care plan will be developed through a contract with Seattle Children's and will be shared with providers and third party payers.

Epilepsia en Washington will continue working with UW Regional Epilepsy Center, School Nurse Administrators, Swedish Epilepsy Center, Seattle Children's, and the Epilepsy Foundation Northwest to ensure that families with children with epilepsy/seizures have medical homes.

Through a contract with UW, CSHCN Nutrition Network dietitians and Washington feeding teams will continue integration with the MHLN.

CSHCN will continue to promote the Medical Home concept in the Oral Health Grant for children with special health care needs.

Kids Matter will continue to promote Medical Home as one of their strategies to enhance access to health care.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data   | 2004 | 2005 | 2006 | 2007  | 2008                     |
|---|------|------|------|-------|--------------------------|
| Annual Performance Objective  | 64.4 | 63   | 64.5 | 66    | 67.5                     |
| Annual Indicator  | 64.4 | 64.4 | 64.4 | 65.3  | 65.3                     |
| Numerator   |      |      |      |       |                          |
| Denominator   |      |      |      |       |                          |
| Data Source   |      |      |      |       | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |      |      |      |       |                          |
| Is the Data Provisional or Final?   |      |      |      | Final | Final                    |
|   | 2009 | 2010 | 2011 | 2012  | 2013                     |
| Annual Performance Objective  | 69   | 70.5 | 72   | 73.5  | 75                       |

**Notes - 2008**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2006**

**PERFORMANCE OBJECTIVES:** The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2012.

**a. Last Year's Accomplishments**

State legislation was passed which included provisions for care within a medical home. Children with Special Health Care Needs (CSHCN) worked with interagency committees to help define components of care and how Medicaid providers could be reimbursed for them.

MCH Assessment and CSHCN reviewed data from the National Survey of Children with Special Health Care Needs (NS-CSHCN, 2005-06) to measure progress in health coverage for children with special needs.

CSHCN reviewed 2007 Child Health Intake Form (CHIF) client data on third-party payment sources. CSHCN provided technical assistance on this data system to local health jurisdictions (LHJs).

Cover All Kids increased publicly funded health insurance to children in families with incomes at

or below 250% federal poverty level (FPL) beginning July 2007. The eligibility was to increase to 300% FPL in January 2009, but implementation was delayed until the end of the 2009 State legislative session. CSHCN was an active member of the Outreach Workgroup and the Quality Assurance and Reimbursement Workgroup which were formed to address the requirements of this legislation.

CSHCN continued to work closely with Medicaid and other statewide programs, such as Foster Care and Early Intervention, and the Title XIX Advisory Committee, on health care access and coverage issues for children with special needs. Two autism grant staff were trained as Family Navigators with the Family to Family Health Information Center to help parents find insurance information.

The Care Coordination workgroup completed a fact sheet to address financing issues including applicable CPT codes. Care coordination information was shared with stakeholders, and activities were integrated in the Medical Home Strategic Plan

Many partners, including health plans, attended the quarterly CSHCN Communication Network meetings. The group routinely discussed access and financial coverage issues.

The section worked with the state Medicaid agency, the Newborn Screening Program, and WIC to provide therapeutic formulas for children who had no insurance which would pay for it.

Parents with children with special health care needs, especially those with children with epilepsy or seizures received information about adequate health insurance during support group activities.

CSHCN consulted with the WithinReach Family Health Hotline and web-based ParentHelp123. WithinReach funding was reduced in July 2007 due to reductions in the MCH Block Grant.

CSHCN continued to work with Family to Family Health Information Center/Family Voices, Parent to Parent, and Fathers Network developing strategies for health insurance access.

CSHCN worked with the MCH Oral Health Program, the state Medicaid agency, other insurance companies to ensure adequate oral health coverage for children with special health care needs.

CSHCN provided limited funding for medically necessary diagnostic and treatment services not covered by another source through the CSHCN Coordinators to assist clients in their communities.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources. |                          |    |     | X  |
| 2. Collect and analyze statewide program information from Child Health Intake (CHIF) and Health Service Authorizations to identify children who have insurance.  |                          |    |     | X  |
| 3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, the Washington Family to Family Health Information Center (Family Voices) and interactions with managed care plans.                              |                          |    |     | X  |
| 4. Provide limited diagnostic and treatment funds to fill gaps in medically necessary services for children with no or inadequate  |                          | X  |     |    |

|  |  |  |   |  |
|--|--|--|---|--|
| coverage.  |  |  |   |  |
| 5. Work with Washington State Department of Social and Health Services, Health and Recovery Services Administration on outreach and quality assurance activities for Cover All Kids. |  |  | X |  |
| 6.   |  |  |   |  |
| 7.   |  |  |   |  |
| 8.   |  |  |   |  |
| 9.   |  |  |   |  |
| 10.  |  |  |   |  |

#### **b. Current Activities**

CSHCN assists in Medicaid outreach activities to increase enrollment of children in publicly funded health coverage. Local CSHCN Coordinators inform families and assist with applications.

The CSHCN Communication Network and MCH/CSHCN Regional Teams and Meetings continue to be venues to share information about medical coverage. Collaboration with health plans focuses on care coordination, patient education and outreach strategies.

CSHCN and MCH Assessment are doing further analysis, making presentations, developing fact sheets and issue briefs using NS-CSHCN 2005-2006 data. Other data sources are being explored for applicable information about children with special needs.

Continued improvements are being made to data collection for the Child Health Intake Form (CHIF) and electronic data transfer which is used by each of the local CSHCN programs to provide statewide data on children served by Title V. CSHCN continues to review and analyze the data submitted to identify children who have insurance and the types of insurance and other funding they rely on for services.

CSHCN continues to work with partners to ensure coverage for therapeutic formulas, oral health services, and limited funding for medically necessary diagnostic and treatment services not covered by other sources.

#### **c. Plan for the Coming Year**

CSHCN will continue to participate in the Title XIX Advisory Committee and other interagency workgroups to implement new legislation that impacts benefit packages and provider reimbursement for enhanced services for children.

The Communication Network will continue to meet quarterly at the state level as a way to inform partners and share information about policies that affect children with special needs and their families and to collectively solve access issues.

The section will invite Department of Social and Health Services, Health and Recovery Services Administration staff to the CSHCN staff meeting quarterly to deal with specific issues regarding health coverage and to ensure CSHCN is aware of the most current information about publicly funded health coverage. CSHCN will work with Washington Family to Family Health Information Center, Family Voices, Parent to Parent, Fathers Network, and other family partners to identify gaps in financing, help families navigate systems of care, and enhance communication between families and providers.

CSHCN and MCH Assessment will continue analysis of 2005-2006 NS-CSHCN data for Washington State. They will collaborate on developing presentations and documents such as fact sheets and issue briefs to explain this data and use it to direct program development. They will also review other data sources for applicable information about children with special needs in Washington State.

Continued improvements will be made to the quality of data collected by the Child Health Intake Form (CHIF). CHIF is used by local CSHCN programs to provide statewide data on children served by Title V. CSHCN will continue to review and analyze the data submitted to identify children who have insurance and the types of insurance and other funding they rely on for services. An interagency data sharing agreement will be finalized and maintained to allow for matching Title V data with Medicaid and the Social Security Administration data.

CSHCN autism grant will increase access to adequate insurance for special needs children through promotion of available insurance resources to parents, and the work of the Combating Autism Advisory Council on health care coverage and access policy issues.

CSHCN will continue providing information about adequate health insurance to new families that join family support groups.

CSHCN will continue to provide limited funding for medically necessary diagnostic and treatment services not covered by other sources. CSHCN will continue to track and project expenditures to meet these needs.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>              |
|---|-------------|-------------|-------------|-------------|--------------------------|
| Annual Performance Objective  | 74.1        | 74.6        | 75          | 76          | 85.5                     |
| Annual Indicator  | 74.1        | 74.1        | 74.1        | 85.4        | 85.4                     |
| Numerator   |             |             |             |             |                          |
| Denominator   |             |             |             |             |                          |
| Data Source   |             |             |             |             | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                          |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>              |
| Annual Performance Objective  | 85.6        | 85.7        | 85.8        | 85.9        | 86                       |

#### Notes - 2008

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2013.

#### Notes - 2007

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN

survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

#### **Notes - 2006**

**PERFORMANCE OBJECTIVES:** The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.1% was chosen through 2012.

#### **a. Last Year's Accomplishments**

Children with Special Health Care Needs (CSHCN) worked with MCH Assessment to review data from the National Survey of Children with Special Health Care Needs 2005-06 (NS-CSHCN) about community systems.

CSHCN continued to provide resource information through direct distribution and via the internet to families, agencies, and organizations to help families find the resources they need.

The CSHCN Nursing Consultant visited each CSHCN Region and surveyed CSHCN Coordinators. The results of this survey will help develop recommendations and prioritize activities to benefit clients and providers.

Using state monies, CSHCN continued funding 16 Neurodevelopmental Centers (NDCs). NDCs deliver early intervention services in a medical home model. Additional state proviso funding (\$1.2 million) from the 2007 Legislative Session was added to CSHCN funding for NDCs for the 2007-2009 biennium.

Caring for Washington Individuals with Autism Task Force (ATF) submitted its report to the Governor in December 2006. Recommendations made were aimed at improving the delivery and coordination of autism services in the state.

CSHCN provided support to ATF through June 2008, as they developed implementation plans and estimated costs for the recommendations from their 2006 report. Support included distribution of the Autism Guidebook for Washington State, which outlined how parents navigate community systems of service for developmental disabilities.

During the National Learning Collaborative, Epilepsia en Washington, developed communication tools to increase communication between parents, primary care providers, specialists, school nurses, and other organizations that manage the care of children and youth with epilepsy. A standardized Seizure Action Plan form was tested and adopted by the University of Washington (UW) Regional Epilepsy Center. Care coordinators and family support organizations in target communities started promoting the use of care organizers, including the seizure action plan.

CSHCN maintained the links between the community-based feeding teams and the CSHCN Nutrition Network for referral services.

Through a contract with the Sacred Heart Children's Hospital, nutrition resources for the East Region were posted on the Hospital's website.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National |                          |    |     | X  |

|  |  |  |   |   |
|--|--|--|---|---|
| Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources.  |  |  |   |   |
| 2. Develop and implement strategies around community care coordination using the WISE pilot outcome evaluation, and information from the National Epilepsy Learning Collaborative and other organizations.                                 |  |  | X |   |
| 3. Maintain network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state and national systems for CSHCN. |  |  |   | X |
| 4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health agencies, and other partners.  |  |  |   | X |
| 5. Assure and promote community-based service system through autism and epilepsy grants and contracts with University of Washington, Seattle Children's, Sacred Heart Children's Hospital, local health and others.                        |  |  | X |   |
| 6.   |  |  |   |   |
| 7.   |  |  |   |   |
| 8.   |  |  |   |   |
| 9.   |  |  |   |   |
| 10.  |  |  |   |   |

#### **b. Current Activities**

CSHCN conducts the following activities to promote community services:

CSHCN contracts with UW, Seattle Children's, Sacred Heart Children's Hospital and others to promote community service. An online resource directory is being revised through [www.cshcn.org](http://www.cshcn.org) website to expand the availability of resource information for needs such as child care, respite, audiology, and other identified needs. Resources are being developed for families of children with epilepsy and autism.

CSHCN will continue to fund the current 16 NDCs.

Epilepsy and Autism Projects improve community-based services for children and youth with epilepsy and autism. They use care coordination strategies to encourage care through medical homes. These projects distribute Epilepsy Care Organizers and the Autism Guidebook for Washington State to individuals, families, and professionals.

CSHSN promotes the development of family-professional partnerships at the community level.

CSHCN promotes local health jurisdiction CSHCN Coordinators' involvement in activities that link families to appropriate services in their local communities.

CSHCN develops tips and tools for families and makes them available through Medical Home Leadership Network, Adolescent Health Transition Project, Center for Children with Special Needs, and CSHCN Program websites.

#### **c. Plan for the Coming Year**

CSHCN, together with state, community, and family partners, will continue to promote community-based services which are accessible, coordinated, family-centered, and culturally competent. Our goal is a system of community-based services that families of children and youth with special health care needs can use easily.

CSHCN will distribute resources, such as Linkages, Starting Point, and Summer Camp Guide, in both English and Spanish. They will review the use of these resources to see if their outreach should be expanded. CSHCN will develop a tool for providers to give families to make it easier for them to find and access resources such as local public health nurses, parent support, and early intervention.

Combating Autism Advisory Council subcommittees will work to improve systems of care including provider screening for developmental disability and referral, increasing access to information about resources, and work on specific gaps in systems for delivery and coordination of services.

NDCs will continue to receive a base amount of state funding. This funding will be lower than in the past, due to the expiration of state proviso funds. Some NDCs may close due to reduced funding from a variety of historical sources.

CSHCN will continue working with UW Regional Epilepsy Center, Swedish Epilepsy Center, Seattle Children's, school administrators, family support organizations, and the Epilepsy Foundation Northwest to provide families with children with epilepsy or seizures with information and materials that will help them access health care services.

CSHCN will work with MCH Oral Health to develop a training curriculum about oral health for children with special health care needs. This curriculum will be aimed at health care providers and dental providers who serve children with special health care needs.

CSHCN will maintain the links between community-based feeding teams and the CSHCN Nutrition Network for referral services.

CSHCN will contract with Sacred Heart Children's Hospital to update East Region nutrition resources on the Sacred Heart Children's Hospital website.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>              |
|---|-------------|-------------|-------------|-------------|--------------------------|
| Annual Performance Objective  | 5.8         | 8.3         | 9.8         | 11.3        | 47.4                     |
| Annual Indicator  | 5.8         | 5.8         | 5.8         | 47.3        | 47.3                     |
| Numerator   |             |             |             |             |                          |
| Denominator   |             |             |             |             |                          |
| Data Source   |             |             |             |             | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                          |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>              |
| Annual Performance Objective  | 47.5        | 47.6        | 47.7        | 47.8        | 47.9                     |

**Notes - 2008**

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2013.

**Notes - 2007**

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

**Notes - 2006**

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2012.

**a. Last Year's Accomplishments**

Children with Special Health Care Needs (CSHCN) continued to contract with the University of Washington (UW) Adolescent Health Transition Project (AHTP) to assess the usefulness of provider tools. Ideas for future provider tool development were obtained through the primary care provider survey and the Special Interest Group (SIG), composed of physicians interested in improving the health care system to transition youth with special needs from pediatric to adult providers. Membership in the SIG included providers from Sacred Heart Children's Hospital in Spokane and Group Health Cooperative to identify and link adolescent health transition activities statewide.

AHTP promoted adolescent transition materials with an emphasis on school nurses, CSHCN Coordinators, families, providers, and other community partners.

CSHCN participated in Office of the Superintendent of Public Instruction's Building Bridges Project to provide materials, including the AHTP Transition Notebook, and contacts for developing the health component in pilot projects to help youth at risk to stay in school and be successful.

CSHCN and MCH Assessment completed a survey of adult primary care providers to gather information about improving transition for youth from pediatric to adult care. Survey results indicated a number of barriers to transitioning to adult providers. A report on the survey was completed and will be used to raise awareness of the challenges involved in this performance measure.

Adolescent Health Transition SIG Newsletter, Spring 2008, volume 1, Number 2 published information on the National Survey of Children with Special Health Care Needs, the Adult Provider Survey update; Adults and Elders Project, and described information for Adult Primary Care Providers available on the AHTP website.

The UW Regional Epilepsy Center worked to ensure that all youth with epilepsy or seizures who attend their center have a completed transition plan from pediatric to adult care.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Contract with the University of Washington, Adolescent Health Transition Project and Center for Children with Special Needs at Seattle Children's Hospital to provide transition information about federal, state, and community programs and services. |                          |    |     | X  |
| 2. Partner with public and private agencies/organizations to enhance transitions.  |                          |    |     | X  |
| 3. Provide ongoing analysis of data on adolescents with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, Washington State Healthy Youth Survey, and other data sources.              |                          |    |     | X  |
| 4.   |                          |    |     |    |
| 5.   |                          |    |     |    |
| 6.   |                          |    |     |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

CSHCN contracts with AHTP to provide information about transition, maintain the AHTP website, and continue SIG. We continue to refine the AHTP Notebook to include revisions recommended by a parent support organization. CSHCN shares information and materials developed by AHTP with other partners. CSHCN works with MCH Assessment to provide analysis of available data, including the National Survey of Children with Special Health Care Needs 2005-2006 (NS-CSHCN) on adolescents with special needs, the Washington State Healthy Youth Survey, and other data sources.

CSHCN developed a fact sheet on transition to provide information on the available assistance to CSHCN youth as they transition to adult life.

Through their epilepsy and autism grants CSHCN is working to improve coordination in the transition from pediatric to adult care. This includes involving youth and families in Advisory Councils, and increasing the disability content in curricula for nurses, doctors, and dentists.

The UW Regional Epilepsy Center continues working to ensure that all youth with epilepsy who attend their center have a completed transition plan from pediatric to adult care the first day of their visit. They also provide youth and their families' information about adult health care, work, and independent life through support groups.

#### **c. Plan for the Coming Year**

CSHCN will continue to share and promote materials developed by AHTP about adolescent transition with CAH, OSPI, the Epilepsy Learning Collaborative, and the Department of Social and Health Services Division of Developmental Disability and Division of Vocational Rehabilitation. This will enhance transition services and families access to them. CSHCN will continue to work with MCH Assessment to provide analysis of available data on adolescents with special needs to partners.

CSHCN will continue to share the results of the Primary Care Provider Survey through presentations and reports. The results of this survey and the discussions about them will be used to develop tools to help providers bring youth with special needs into their practices and to reduce barriers to successful transition.

Epilepsy and Autism Projects will continue to work with a variety of partners to help families and youth receive the services they need to transition to adult life. This includes transitions to adult health care, work and independence.

CSHCN will contract with AHTP to gather information about transition from federal, state, and community programs and services and provide it to families and providers. Activities will include maintenance of the AHTP website and continuation of the Special Interest Group which is composed of physicians interested in improving the health care system to transition youth with special needs from pediatric to adult providers. In addition, work will continue on refining the AHTP Notebook to include revisions recommended by a parent support organization.

CSHCN will continue to work with the UW Regional Epilepsy Center, Seattle Children's, and Swedish Epilepsy Center to ensure that all youth with epilepsy or seizures who visit their centers have completed transition plans from pediatric to adult care. Epilepsy Foundation Northwest and family support organizations will continue provide support to youth who are transitioning to adult life.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>    |
|---|-------------|-------------|-------------|-------------|----------------|
| Annual Performance Objective  | 76.4        | 77          | 78          | 79          | 79             |
| Annual Indicator  | 77.7        | 77.8        | 77.6        | 73.9        | 73.9           |
| Numerator   | 61962       | 62309       | 64358       | 62089       |                |
| Denominator   | 79745       | 80089       | 82935       | 84017       |                |
| Data Source   |             |             |             |             | See field note |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>    |
| Annual Performance Objective  | 80          | 80          | 81          | 81          | 82             |

#### Notes - 2008

Data are not yet available

#### Notes - 2007

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. A one percent increase every two years was chosen.

Numerator data came from the National Immunization Survey 2007, Centers for Disease Control

and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

#### **Notes - 2006**

**PERFORMANCE OBJECTIVES:** A combination of trend analyses and comparisons to other states were used to create the future objectives. Recent Washington State rates were as follows: 2003 = 75.3%, 2004 = 77.7%, and 2005 = 77.8%. Therefore, a one percent increase every two years was chosen.

Numerator data came from the National Immunization Survey 2006, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

#### **a. Last Year's Accomplishments**

After several years of gains, childhood immunization rates in Washington have dipped slightly, according to the 2007 National Immunization Survey. There were increases in some specific vaccines but decreases in some of the older vaccines. Most parents are vaccinating their children; however, we know that some parents are doing so with anxiety, some are delaying or deferring vaccines, and some are not giving their children any vaccines. The Immunization Program CHILD Profile (IPCP) continued working with parents, health care providers, and health systems to raise immunization rates. In addition, the shortage of Haemophilus influenzae type b (Hib) vaccine may affect coverage rate for this series.

IPCP worked with Head Start and Washington State's preschool programs [Early Childhood Education and Assistance Program (ECEAP)] to encourage them to use the immunization registry. Our goal is for all of these programs to use the registry by December 2009. IPCP also helped schools use the registry to provide families with their immunization records, which reduces the number of families who used convenience exemptions.

IPCP and OMCH disseminated feedback and analyzed results from a hospital-based medical record and policy/procedure review. The purpose of this review was to see if mothers are being screened for hepatitis B. Babies born to positive mothers or mothers of unknown status need to receive hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine within 12 hours of birth. Information from the records review was used to assist focused educational outreach to hospitals and care providers. IPCP and the Centers for Disease Control and Prevention (CDC) continued working on a national-level medical record review for a snapshot of practices in Washington State hospitals.

IPCP contracted with Local Health Jurisdictions (LHJs) for Vaccines for Children/Assessment Feedback Incentives Exchange (VFC/AFIX) site visits to 25% of enrolled immunization providers. IPCP staff visited another 5% and provided technical assistance and training to both LHJs and providers. Site visits were used to make sure the providers are enrolled in the registry and knowledgeable about its use. The provider's immunization coverage rates were compiled and discussed to help develop strategies providers could use to increase coverage. IPCP also continued to implement the registry provider recruitment plan.

IPCP provided technical assistance to tribes to help raise vaccination rates. We also participated in the American Indian Health Commission for Washington State (AIHC). IPCP and the State

Board of Health (SBOH) worked on changes to school and child care immunization requirements. These changes will align these requirements with the Advisory Committee on Immunization Practices' (ACIP) 2008 immunization schedules.

IPCP contracted with LHJs to work with providers on proper vaccine use and storage. LHJs ensured access to vaccination by either partnerships or direct administration.

CHILD Profile Health Promotion worked to increase the number of parents who are sent well child and immunization reminders.

IPCP worked on several initiatives to improve vaccination rates by focusing their efforts on the vaccines in this series with the lowest rates. We worked to improve the rates for these vaccines by providing education to families, providers, and the public; sending reminders to parents; guiding the ordering and receipt of vaccine; getting providers to use the registry; giving providers vaccine information; and making site visits to providers.

Kids Matter, a partnership and strategic plan/framework developed through the OMCH Early Childhood Comprehensive Systems (ECCS) grant, continued telling providers about the importance of immunization and helped raise immunization of kids aged 0--5 years.

Child care health consultants (CCHCs) worked with staff who provide child care for infants and toddlers. Immunizations were a frequently discussed topic. CCHCs provided tools, such as Keep on Track; and advice on how to keep and use immunization records, how to communicate with parents regarding the need for immunizations, and how to fill out state-required reports on immunizations. CCHCs also conducted in-depth reviews of immunization records in child centers and found that many were below standard. They then developed resources and trainings specifically to help those providers.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.  |                          |    |     | X  |
| 2. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.   |                          |    |     | X  |
| 3. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.   |                          |    | X   |    |
| 4. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule. |                          |    |     | X  |
| 5. Implement 4th DTaP initiative to increase timely administration of the 4th DTaP dose and overall immunization rates.  |                          |    | X   |    |
| 6. Assist providers of child care for infants and toddlers to organize and interpret immunization records, communicate with parents, and fill out state-required immunization reports.                                   |                          | X  |     |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

By April 2009, 80% of Head Start/ECEAPs use the registry. IPCP continues to help schools use the registry to reduce the use of convenience exemptions.

IPCP and contracted LHJs visit at least 30% of VFC/AFIX enrolled sites. IPCP trains and assists providers. We compile and share provider coverage rate data to help raise rates. We also contract with LHJs to work with providers on vaccine use and storage, and to assure community access to vaccination.

IPCP works with AIHC and tribes in projects to raise rates and continues to work with SBOH to update school and child care entry requirements.

IPCP work includes: health promotion and community awareness, education, reminders, facilitating ordering and receipt of vaccine, assisting with provider registry use and office visits. Kids Matter informs early childhood providers about immunizations and promotes immunizing kids 0--5 years. By April 2009, 53% of 19--35 month-olds in the registry have complete records.

CCHCs discuss immunization with providers of infant and toddler child care. They provide tools, such as Keep on Track; and advice on how to keep and use immunization records; communicate with parents regarding the need for immunizations, and fill out state-required reports on immunizations.

### **c. Plan for the Coming Year**

IPCP's will continue to work toward the goal of having immunization registry agreements with all Head Start/ECEAP programs by December 2009. IPCP will also continue to work with schools to use the registry to provide families with their immunization records, to help reduce the number of families who use convenience exemptions.

IPCP will work to increase the percentage of children aged 19--35 months in the Immunization Registry who have up-to-date immunization records to 60% by September 2010.

IPCP will continue contracting with LHJs to complete VFC/AFIX site visits to at least 25% of all enrolled immunization provider sites. IPCP staff will complete site visits to an additional 5% this year. IPCP will continue to provide technical assistance and training to both LHJs and providers. Site visits will be used to make sure that the provider is enrolled in the registry and knowledgeable about its use. The provider's immunization coverage rates will be compiled and discussed to develop strategies for providers to use to increase coverage. IPCP will continue to implement the registry provider recruitment plan.

IPCP will continue to encourage tribes to participate in projects that include activities to enhance vaccination coverage rates. Technical assistance will be provided. IPCP will continue to participate with AIHC.

IPCP will continue working with SBOH on updating the school and child care immunization requirements. These changes will make entry requirements consistent with the ACIP Recommended Childhood and Adolescent Immunization Schedules.

All LHJs will continue to have contracts with IPCP. LHJs will continue to work with local providers to ensure proper use and storage of vaccines. LHJs will continue assuring community access to vaccination either by administering vaccinations directly or facilitating vaccination through community partnerships.

IPCP will continue to focus health promotion and community awareness efforts on vaccines in this series with the lowest rates. They will do this providing parent education on the importance of immunization; sending checkup reminders to parents; facilitating the ordering and receipt of vaccine; giving providers vaccine information, encouraging them to use the registry, and visiting

their offices. The current Hib shortage and limited supply of hepatitis B vaccine may affect rates.

Kids Matter will continue to inform early childhood providers of the importance of immunizations. This is a priority area in the Kids Matter Framework and is included in and integrated across the 5 required components of the ECCS Grant.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>    |
|---|-------------|-------------|-------------|-------------|----------------|
| Annual Performance Objective  | 16.1        | 14          | 15.5        | 15.4        | 15.3           |
| Annual Indicator  | 15.5        | 14.9        | 15.2        | 16.1        | 16.1           |
| Numerator   | 2006        | 1966        | 2062        | 2217        |                |
| Denominator   | 129120      | 132042      | 135315      | 137767      |                |
| Data Source   |             |             |             |             | See field note |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>    |
| Annual Performance Objective  | 15.2        | 15.1        | 15          | 14.9        | 14.8           |

#### Notes - 2008

Data are not yet available

#### Notes - 2007

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening off of the rate at 14.0. The 75th percentile state was at 15%, which was close to where Washington was at with 15.2%. A target of 15.5 % was chosen for 2006 with a 0.1 annual decrease targeted every year afterward.

#### Notes - 2006

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening off of the rate at 14.0. The 75th percentile state was at 15%, which is where Washington is at. Therefore, a 0.1 annual decrease was chosen.

#### a. Last Year's Accomplishments

A steady trend over the last decade indicates a decline in teen pregnancy and birth rates in Washington State, until 2003. Since then there were no significant changes in the rate. In Washington for 2003-2005 combined, live births to women 15-17 years old were significantly higher among Hispanics, American Indians, Alaska Natives, and blacks than among whites and Asians and Pacific Islanders.

The Healthy People 2010 goal is to reduce teen pregnancy rates. Washington State exceeded this goal in 2007 and fares well compared to other states. In 2007, 28.7 per 1,000 female

adolescents aged 15-17 became pregnant in Washington, up from 27.6 in 2006. Pregnancy rates are estimated from birth, abortion, and fetal loss records. It is possible to calculate birth rates, but not pregnancy rates by race and Hispanic origin, because reported abortion data frequently lacked information about race and Hispanic origin. Recently, we have been observing increases in pregnancy and birth rates among women over 25, and we are carefully watching the trends among younger women, especially given the demographic and economic changes in the state.

Child and Adolescent Health (CAH) funded 12 sites to implement an abstinence-focused media literacy curriculum. Curriculum improvements were made based on evaluation results.

CAH sponsored a series of statewide conference calls on adolescent health, including information related to teen sexual behavior. These conference calls had up to 50 participants each and received positive evaluations.

CAH worked with the Office of the Superintendent of Public Instruction (OSPI) to review sexual health education curricula to determine consistency with the Washington State Healthy Youth Act (HYA). HYA requires sexuality education provided by public schools be medically and scientifically accurate; age appropriate; appropriate for students regardless of gender, race, disability status, or sexual orientation; and include information about abstinence and other methods of preventing unintended pregnancy and sexually transmitted disease. OMCH reviewed over sixty curricula for medical and scientific accuracy. CAH and OSPI developed a list of curricula that comply with the Act, and made them available to schools and organizations across the state. OMCH in collaboration with OSPI and other organizations conducted four regional trainings for school personnel on the Healthy Youth Act.

CAH staff attended conferences and trainings in an effort to research and investigate strategies to reduce disparities among target populations for teen pregnancies and sexually transmitted infections.

CAH funded two school-based health centers that provide health care to students including reproductive health care. CAH funded eleven planning grants for school-based health centers across the state.

Due to changes in state law, DOH was unable to continue the abstinence only media literacy projects in public schools. OMCH conducted formative research and implemented a pilot project to convert our abstinence only media literacy curriculum into a comprehensive program.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Sponsor statewide adolescent health conference call series for professionals working with youth.   |                          |    |     | X  |
| 2. Partner with state and local agencies to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH/Office of the Superintendent of Public Instruction (OSPI) Guidelines. |                          |    |     | X  |
| 3. Fund two school based health centers to deliver health care and education, including reproductive health care, to students.  | X                        |    |     |    |
| 4. Fund 11 planning grants for school based health centers.   |                          |    |     | X  |
| 5. Review sexual health education curricula for medical and scientific accuracy as required by state legislation.   |                          |    |     | X  |
| 6. Convert an abstinence based media literacy curriculum to a comprehensive based curriculum.   |                          | X  |     |    |
| 7.  |                          |    |     |    |

|     |  |  |  |  |
|-----|--|--|--|--|
| 8.  |  |  |  |  |
| 9.  |  |  |  |  |
| 10. |  |  |  |  |

#### **b. Current Activities**

While overall birth rates among youth aged 15-17 have remained the same over the last year, rates have increased among Hispanics, American Indians, Alaska Natives, and blacks. As a result, OMCH is expanding the comprehensive based media literacy project to nine sites across the state focusing efforts on those groups with higher rates. At this time, we do not have the funding to evaluate the program.

CAH is reviewing sexual health education curricula for medical and scientific accuracy as requested by the OSPI. We are also responding to public inquires about this issue. We will update the curricula list annually in coordination with OSPI. OMCH continues to provide technical assistance, consultation and build capacity around comprehensive sex education.

CAH provides partial funding for two school-based health centers to provide services to students, including reproductive health care and education. CAH provides technical assistance to the eleven planning grant communities.

OMCH did not have funds to sponsor a statewide adolescent health conference. Instead we are conducting a series of conference calls on adolescent health topics such as using youth voice, academic achievement and health, and results of the Healthy Youth Survey.

With Title V Abstinence Education funds, OMCH is conducting focus groups in nine sites across the state with youth ages 12-15 and their caregivers and parents. These focus groups will inform a statewide media campaign to be conducted in FFY 10.

#### **c. Plan for the Coming Year**

OMCH will continue the adolescent health conference call series in FFY 10. We will also seek funding to hold a second state-wide adolescent health conference for professionals working with youth.

With the data collected from the focus groups conducted this year, OMCH will implement a state wide media campaign targeting youth ages 12-15 and their parents and caregivers. The goal of the campaign is to encourage parents to speak with their children about sex and youth to delay sexual initiation.

OMCH will continue to fund two existing school-based health centers and will evaluate available funding to expand the number of centers. The inclusion of reproductive services in school-based health centers has been shown to improve access for adolescents to these services, but creates more political controversy in creating the centers. OMCH will explore this issue further as part of supporting creation of new centers.

OMCH will explore strategies to continue expansion of the Take it Seriously, Sex, Abstinence and the Media (TISSAM) media literacy curriculum. We will conduct train the trainer events, and create video and online training tools on how to implement the curriculum

OMCH will continue to review sexual health education curricula as required by state law. In cooperation with OSPI, OMCH will develop trainings on medical and scientific accuracy for school personnel.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>                              |
|---|-------------|-------------|-------------|-------------|--|
| Annual Performance Objective  | 49.6        | 55.5        | 55.5        | 50          | 50                                       |
| Annual Indicator  | 55.5        | 50.4        | 50.4        | 50.4        | 50.4                                     |
| Numerator   | 45689       | 41460       | 41460       | 42971       |  |
| Denominator   | 82322       | 82261       | 82261       | 85260       |  |
| Data Source   |             |             |             |             | Washington State<br>2005 Smile<br>Survey |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |  |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                                    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                              |
| Annual Performance Objective  | 50          | 50          | 50          | 50          | 50                                       |

### Notes - 2008

Data are not yet available

### Notes - 2007

**PERFORMANCE OBJECTIVES:** The Smile Survey is only conducted every 5 years, and therefore only two data points exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The Healthy People 2010 goal of 50% was chosen as the future objective through 2013, since it is attainable and will be an improvement on the historical decrease of dental sealants.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2005, thirty-nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. The indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

The Smile Survey will be conducted again this coming school year beginning in the Fall 2009 school term and finishing in the Spring 2010 term.

The Smile Survey was developed in Washington State has been adapted and implemented by several other states.

### Notes - 2006

**PERFORMANCE OBJECTIVES:** The Smile Survey is only conducted every 5 years, and therefore only two data points exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The Healthy People 2010 goal of 50% was chosen as the future objective through

2012, since it is attainable and will be an improvement on the historical decrease of dental sealants.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2005, thirty-nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. The indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

The Smile Survey was developed in Washington State has been adapted and implemented by several other states.

#### **a. Last Year's Accomplishments**

OMCH continued a statewide surveillance system to monitor the prevalence of dental sealants and other oral health indicators. The Oral Health program reviewed sealant data, for both Medicaid and non-Medicaid individuals through an annual consultation with the Department of Social and Health Services (DSHS) and private providers who deliver this service in schools.

Legislation passed in 2007 required DOH to submit a report to the legislature evaluating the effectiveness of school sealant programs in the state. The Oral Health Program worked with the Office of Health Professions Quality Assurance (OHPQA) to submit this report along with recommendations to the legislature.

The Oral Health program worked with local health jurisdictions (LHJs) to implement new sealant programs. We were successful in starting a new sealant program in Spokane County in 2008.

OMCH offered oral health funding to all LHJs to provide sealants, either directly or through contracting or coordinating services with other dental providers.

The Oral Health program worked with the Washington State Oral Health Coalition to develop a statewide system to improve coordination with dental providers, LHJs, school administration, and schools in order to increase access to sealant programs.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Fund all LHJs to provide sealants.   |                          |    | X   |    |
| 2. Promote and coordinate sealant programs around the state.                        |                          |    |     | X  |
| 3. Develop evaluation plan for school sealant programs.                             |                          |    |     | X  |
| 4. Collect statewide sealant data.  |                          |    |     | X  |
| 5. Work with state coalition to improve coordination in state for sealant programs. |                          |    |     | X  |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

**b. Current Activities**

The Oral Health Program is funding all LHJs to provide sealants, either directly or through contracting or coordinating services with other dental providers.

LHJ will submit sealant data for 2007-2008 to the Oral Health Program. This data will be included in the surveillance system. (Fig 4a, NPM09, Act 4)

Private dental providers that participate in providing sealants will provide sealant data to OHPQA. The Oral Health program is working with OHPQA to analyze this data and develop a report to be submitted to the Legislature.

The Oral Health Program is continuing to work with the LHJs, the state coalition, and dental providers to identify new opportunities to expand the school sealant programs in the state.

**c. Plan for the Coming Year**

The Oral Health Program will continue funding all LHJs to provide sealants, either directly or through contracting or coordinating services with other dental providers.

The OMCH Oral Health Program will continue to work with the LHJs, the state coalition, and dental providers to identify new opportunities to expand the school sealant program.

LHJs will submit sealant data for 2009 to the Oral Health Program. This data will be included in the surveillance system.

The Oral Health Program will also collect data on sealant prevalence in third grade children as a part of the Smile Survey 2010.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>    |
|---|-------------|-------------|-------------|-------------|----------------|
| Annual Performance Objective  | 2.9         | 2.5         | 2.5         | 2.4         | 2.4            |
| Annual Indicator  | 1.8         | 3.1         | 1.7         | 2.0         | 2              |
| Numerator   | 23          | 39          | 21          | 26          |                |
| Denominator   | 1257310     | 1259643     | 1270785     | 1281739     |                |
| Data Source   |             |             |             |             | See field note |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>    |
| Annual Performance Objective  | 2           | 2           | 2           | 2           | 2              |

**Notes - 2008**

Data not yet available

**Notes - 2007**

PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed, possibly due to use of seat belts, child safety seats, and airbags. Rates are prone to a great degree of variance due to small numerators. Many years of data were used to assess the trends, therefore future targets may not appear to align with the most recent indicators. The 95% confidence interval of the rate in 2007 was (1.3, 3.0) which includes the performance objective (2.4), and we conclude the indicator and the objective are not statistically significantly different. After discussions with program and assessment staff we decided to revise the performance objective downward based on the data in the last four years. The objective of 2.3 per 100,000 had been chosen as a goal through 2013, however in all but one of the past four years that goal had been achieved and bettered, a new goal which reflects the present rate of 2.0 has been settled on for future objectives.

The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is from the Office of Financial Management Population Forecast.

**Notes - 2006**

PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed, possibly due to use of seat belts, child safety seats, and airbags. Rates are very variable because of small numerators. Many years of data were used to assess the trends, therefore future targets may not appear to align with the most recent indicators. The 95% confidence interval of the rate in 2006 was (1.0, 2.5) which includes the performance objective (2.5), and we conclude the indicator and the objective are not statistically significantly different. Using a conservative approach, a 0.1 decrease every two years was chosen with a leveling off at 2.3.

**a. Last Year's Accomplishments**

OMCH provided limited technical assistance to local Child Death Review (CDR) teams. CDR is a community-based process for reviewing information about unexpected deaths of children, such as motor vehicle crash deaths, in order to make prevention recommendations. The data that are collected are used to generate reports that provide statewide and county data which are presented to county commissioners, boards of health, and community groups. MCH Assessment responds to requests for data. Since 2005, OMCH has worked with the National MCH Center for CDR to explore the use of a multi-state database. In spring 2008, OMCH decided to use this database and developed a transition plan.

In 2008 DOH received new state funds for the CDR program. OMCH worked with the Injury and Violence Prevention Program in the DOH Office of Community Health Systems to allocate these funds to CDR teams in local health jurisdictions and to pay for DOH staff time to work on the database conversion.

CHILD Profile distributed car seat, booster seat, and air bag safety information to parents of children aged birth to 6 years.

OMCH worked with the Harborview Injury Prevention Research Center to implement the Harborview Injury Prevention Grant, a CDC demonstration project, with six local CDR teams. The goal of the project was to link regional Emergency Medical Services (EMS) injury prevention coordinators to local teams. As part of the demonstration project, Harborview refined a web-based decision-making tool so CDR teams can review promising practices, strategies and evidence-based interventions (<http://depts.washington.edu/cdreview>). The website includes interventions to reduce motor vehicle occupant injuries, including recommendations specific to children and parents.

OMCH collaborated with the Office Community Health Systems, Emergency Medical Services and Trauma Systems section (EMS-T) including the Injury and Violence Prevention program on

activities that were shared priorities including development of a State Injury Prevention Plan.

OMCH worked with Safe Kids Washington to develop a statewide network of local car seat technicians and fitting stations. Washington State has 18 local Safe Kids Coalitions who work in communities to check car seats, distribute free and reduced cost car seats to needy families, establish permanent fitting stations, and educate and bring awareness of child passenger safety.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Disseminate car seat, booster seat, and air bag safety information to parents statewide through CHILD Profile. |                          |    | X   |    |
| 2. Review unexpected deaths of children through local Child death Review (CDR) teams.                             |                          |    |     | X  |
| 3. Conduct surveillance of motor vehicle crash deaths to children through CDR process and disseminate data.       |                          |    |     | X  |
| 4. Participate in Harborview Injury Prevention grant.   |                          |    |     | X  |
| 5. Collaborate with DOH Office of Community Health Systems to promote statewide injury prevention activities.     |                          |    |     | X  |
| 6. Collaborate with EMS-T section to develop State Injury Prevention Plan.  |                          |    |     | X  |
| 7. Provide and disseminate data reports identifying risk factors, population statistics and recommendations.      |                          |    |     | X  |
| 8. Transition to multi-state database for CDR.  |                          |    |     | X  |
| 9. Promote new booster seat law to local health jurisdictions and other partners.                                 |                          |    | X   |    |
| 10.   |                          |    |     |    |

#### **b. Current Activities**

Between 1990 and 2008 there has been a significant downward trend in deaths to young children caused by motor vehicle crashes. Variation from year to year is due to the small numbers involved.

OMCH works with the 18 local CDR teams. These teams make policy and practice recommendations, including strategies for reducing child deaths due to motor vehicle crashes. Transition to the multi-state database is nearly completed. OMCH sponsored a CDR Conference attended by 40 CDR Coordinators and stakeholders. Legislation passed requiring DOH to assist CDR Coordinators with data collection and provide technical assistance.

CHILD Profile sends car seat, booster seat, and air bag safety information to parents of children aged 0-6 years. Information is refined as statewide data changes.

The Healthy Youth Survey (HYS) was administered in October 2008 in schools across the state. HYS includes questions on drinking and driving, wearing seatbelts, and riding with a drinking driver.

OMCH works with Harborview Injury Prevention Research Center to look for new opportunities to collaborate.

OMCH staff collaborates with the Office of Community Health Systems -- EMS-T and Injury and Violence Prevention shared activities. We will begin using community partners to market the State Injury Prevention Plan as we begin its implementation.

OMCH continues to work with Safe Kids Washington to bring awareness and education to parents, caregivers and community partners about child passenger safety.

### c. Plan for the Coming Year

OMCH will work with the 18 current local CDR teams and any additional teams that are formed. These teams make policy and practice recommendations to reduce the rate of child and youth deaths. These include strategies for reducing child deaths due to motor vehicle crashes. Local CDR teams will continue to add data to the multi-state database.

OMCH will implement legislation passed in 2009 requiring DOH to assist CDR Coordinators with data collection, provide technical assistance, and encourage communication among CDR teams. No state funds were allocated for this work. The legislation stipulates that these activities must be conducted using only federal and private funding.

CHILD Profile will send car seat, booster seat, and air bag safety information to parents of children aged 0-6 years. Information will be refined as statewide data changes.

OMCH will work with Harborview Injury Prevention Research Center to look for new opportunities to collaborate.

OMCH will collaborate with EMS-T and Injury & Violence Prevention on shared activities. OMCH will continue to implement the State Injury Prevention Plan. OMCH will participate on the DOH Injury Prevention Workgroup.

OMCH will work with Safe Kids Washington to connect local public health MCH staff to their local Safe Kids Coalition. The collaboration between the two entities will help develop a network to provide constant, non-duplicative child passenger safety services.

OMCH plans to continue to implement the 2010 Healthy Youth Survey.

### **Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>    |
|---|-------------|-------------|-------------|-------------|----------------|
| Annual Performance Objective  |             |             | 52          | 53          | 53             |
| Annual Indicator  | 52.0        | 55.5        | 58.8        | 57.3        | 57.3           |
| Numerator   | 42492       | 45857       | 47323       | 50951       |                |
| Denominator   | 81715       | 82625       | 80482       | 88921       |                |
| Data Source   |             |             |             |             | See field note |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                |
| Is the Data Provisional or Final?   |             |             |             | Provisional | Provisional    |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>    |
| Annual Performance Objective  | 58          | 58          | 58          | 58          | 58             |

**Notes - 2008**

Data are not yet available

**Notes - 2007**

This measure changed in 2006, from breastfeeding at hospital discharge to six months or more after delivery. Rates are based on the National Immunization Survey, and are highly variable due to small sample size. The 95% confidence interval for 2007 was (50.8, 63.8) which includes the performance objective. After discussions with program and assessment staff we decided to revise the performance objective upward based on the data from the last two years.

The source of this data is the 2007 National Immunization Survey (NIS) which is reported for children born in 2005. As of July 2009 these data were reported as provisional by CDC. The numerator is based on the proportion of women who reported breastfeeding at six months or longer. The denominator was obtained from the live birth file, for Washington residents.

**Notes - 2006**

This measure changed in 2006, from breastfeeding at hospital discharge to six months or more after delivery. Rates are based on the National Immunization Survey, and are highly variable due to small sample size. The 95% confidence interval for 2006 was (54.2, 63.4) which includes the performance objective.

The source of this data (58.8%) is the 2006 National Immunization Survey (NIS) which is reported for children born in 2003. The numerator is based on the proportion of women who reported breastfeeding at six months or longer. The denominator was obtained from the live birth file, for Washington residents.

**a. Last Year's Accomplishments**

OMCH recognized breastfeeding as one of the most important public health interventions for helping to ensure healthy mothers and infants.

First Steps and the Women, Infant and Children Supplemental Nutrition Program (WIC) reviewed data on breastfeeding initiation and duration. The goal of this review was to evaluate progress in relation to the Healthy People 2010 goals and determine what interventions and changes within programs were needed. In 2008, 43.8% of women served by WIC continued breastfeeding their infants until 6 months of age (WIC data), which was the same as 2007 but still below the Healthy People 2010 goal of 50%. Another data source, the National Immunization Survey (NIS) showed Washington State breastfeeding rates at 6 months of age to be at 57.3%, which is up from the 56.6% last year.

While the WIC number represents 44,000 women, all of whom are under 185% of federal poverty level (FPL), the NIS is a small sample but representative of the entire population of new Washington mothers.

The following work promoted increased breastfeeding rates by mothers in Washington State, especially women served by Medicaid:

First Steps continued to require that Maternity Support Service (MSS) providers offer breastfeeding health messages to all women. Requiring breastfeeding health messages in MSS ensured women were given important health messages regarding breastfeeding along with local support. The requirement also kept breastfeeding a priority for MSS providers.

First Steps offered providers online breastfeeding training and evaluated staff knowledge based on their test results. Over 40% of MSS Registered Dietitians have taken the online training and passed the knowledge testing with a score of 80% or above. WIC provided Evergreen lactation training for 15 MSS providers that improved knowledge and consultation skills.

Most Washington parents of children aged birth-6 years received CHILD Profile health promotion letters in the mail that included breastfeeding support and tips.

OMCH recommended lactation support at all hospitals through the Perinatal Level of Care Guidelines document.

First Steps updated and distributed breastfeeding talking points to 120 MSS dietitians. The messages provided Registered Dietitians with helpful communication tips to encourage women to breastfeed longer.

MIH/WIC contracted with WithinReach who housed the Washington State Breast Feeding Coalition and promoted breastfeeding messages and policies state-wide.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Provide breastfeeding support and education to low income women receiving Medicaid through First Steps Maternity Support Services (MSS).   |                          | X  |     |    |
| 2. Provide training for MSS providers in breastfeeding support and teaching techniques.   |                          | X  |     |    |
| 3. Recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.   |                          |    |     | X  |
| 4. Review breastfeeding data from the Women, Infants, and Children (WIC) Client Information Management Systems (CIMS), PRAMS, and the National Immunization Survey data.                  |                          |    |     | X  |
| 5. Through state level breastfeeding work group, improve workplace support for breastfeeding mothers; Draft work place policies and building guidelines for state agencies in Washington. |                          |    | X   |    |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

#### **b. Current Activities**

First Steps requires that breastfeeding health messages and local resources are provided to all Maternity Support Services (MSS) clients.

OMCH continues to monitor client breastfeeding rates by reviewing duration data from WIC Client Information Management Systems (CIMS) and the National Immunization Survey (NIS) yearly.

First Steps updates and distributes provider breastfeeding talking points to assist them in communications that will support clients in sustaining long-term breastfeeding.

First Steps and WIC continue to notify providers about local breastfeeding trainings and resources.

First Steps offers providers online breastfeeding training and evaluates staff knowledge based on their test results.

OMCH recommends lactation support at all hospitals with delivery services as recommended in

the Perinatal Level of Care Guidelines document.

OMCH runs a state level breastfeeding workgroup that is aiming at improve workplace policies and resources for working women. The workgroup will compile resources to share with new mothers and supervisors via the DOH intranet. The group will explore improving breastfeeding support for employees in state agencies.

### **c. Plan for the Coming Year**

OMCH will evaluate breastfeeding duration data from WIC CIMS and National Immunization Survey to determine Washington's progress in relation to the Healthy People 2010 goals and to assess program improvement.

Assisting women to continue breastfeeding after returning to work may increase the percent of women who continue to breastfeed their babies at 6 months. OMCH will continue to promote breastfeeding duration by convening a cross-agency breastfeeding workgroup with the goal of improving DOH breastfeeding policies, support system, and work environment. The workgroup will present a draft workplace breastfeeding policy for DOH consideration. They will also work with other state agencies regarding breastfeeding support for employees, including information and support for new moms, information for supervisors, and agency policies.

CHILD Profile will continue to mail families health promotion letters that include information on breastfeeding to parents of children aged birth-6 years.

First Steps providers will continue to provide breastfeeding MSS clients with health messages and local resources. Requiring breastfeeding health messages will ensure breastfeeding continues to be a priority in the program and with local providers.

First Steps will continue to offer the online breastfeeding training to providers and will keep providers informed of other local trainings related to breastfeeding. Training providers will help them be more confident in providing information to clients, supporting their breastfeeding needs, and helping them sustain duration.

OMCH will recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.

The Washington State Breast Feeding Coalition, housed at WithinReach, will continue to promote breastfeeding state-wide, and to promote policies supporting breastfeeding. Their focus will be pm improving workplace support in a specific sector such as hospitals.

### **Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>      |
|---|-------------|-------------|-------------|-------------|------------------|
| Annual Performance Objective  | 90          | 90          | 90          | 96.5        | 97               |
| Annual Indicator  | 88.0        | 94.4        | 96.5        | 95.3        | 95.7             |
| Numerator   | 69958       | 76241       | 77792       | 80067       | 81303            |
| Denominator   | 79507       | 80728       | 80607       | 84043       | 84913            |
| Data Source   |             |             |             |             | WA EHDDI program |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last |             |             |             |             |                  |

|  |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|
| year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?  |             |             |             | Final       | Final       |
|  | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| Annual Performance Objective   | 97.5        | 98          | 98.5        | 99          | 99.5        |

#### **Notes - 2008**

Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

#### **Notes - 2007**

Data reported by the EHDDI program.

A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

#### **Notes - 2006**

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

In CY 2006, 96.5% of infants born in Washington hospitals received newborn hearing screening.

#### **a. Last Year's Accomplishments**

In 2008, Washington State did not meet its program target (97%) for screening infants for hearing loss prior to discharge or at least by one month of age, but did exceed the national goal of 95% for the third year in a row. Data from the Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) tracking and surveillance system show that 96% of infants born in 2008 received an initial hearing screen before hospital discharge. 1% of the infants born during that period did not receive a newborn hearing screen because parents refused the screen. Of the infants who did not receive their hearing screen before hospital discharge, 62% received a hearing screen at a later time, typically before one month of age.

Because hearing screening is most beneficial in conjunction with appropriate follow up, the EHDDI Program worked to improve all aspects of the program: screening, follow-up for re-screens and diagnostic audiology, referral to early intervention services, and availability of trained early intervention providers. The EHDDI program contracted with Seattle Children's to provide

technical assistance to birthing hospitals, which helped improve screening quality and kept referral rates low. Under this contract, Seattle Children's also hosted the Washington State Universal Newborn Hearing Screening (UNHS) Coordinator's Meeting for both the east (Spokane, May 16, 2008) and west (Seattle, June 8, 2008) sides of the state. At these meetings, UNHS coordinators and screeners shared strategies for improving newborn hearing screening and referral rates with other coordinators and professionals and gathered new ideas to take back to their UNHS programs.

EHDDI also contracted with Washington Sensory Disabilities Services (WSDS) to provide ongoing early intervention training to counties. Eight new counties participated in the 2007-08 trainings, which included training on the SKI-HI Curriculum (a family-centered program for infants and young children with hearing loss), taught by two authors of the curriculum. Masters-level trained early intervention providers who specialize in services for children who are deaf or hard of hearing provided consultation and one-on-one coaching to county participants. The WSDS contract also provided funding for 13 families with birth-to-3 year olds with hearing loss to attend the annual family weekend, May 2-4, 2008, in Ellensburg, Washington.

In November 2007, DOH hosted the third statewide EHDDI Summit in Wenatchee, Washington. EHDDI Summits aim to expand coordination, planning, and awareness among primary care providers, other health professionals, parents, and other key stakeholders in EHDDI follow-up statewide.

In March 2008, the EHDDI program began a National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative. This Learning Collaborative was a nine month project designed for teams to share and implement ideas for more timely, appropriate, coordinated, and family-centered care. The EHDDI Learning Collaborative Team included parents, public health professionals, physicians, audiologists, care coordinators, early interventionists, and a Medicaid representative. Through this engaging and challenging project, our team developed and tested strategies to improve care for infants at each stage of the EHDDI system process, from screening through referral for early intervention.

The EHDDI program analyzed parent survey results to better understand why some infants do not receive necessary audiologic evaluations. Surveys were sent to mothers of infants who did not pass hearing screening and were reportedly referred for audiologic evaluation. The analysis compared parental experience and potential barriers between families who brought their infant to an audiologist and those for whom the EHDDI program had no further data. Birth certificate and EHDDI data were also used to examine differences in demographics and hearing screening histories between these two groups.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Develop and maintain an early hearing-loss detection, diagnosis, and intervention (EHDDI) tracking and surveillance system.                        |                          |    |     | X  |
| 2. Contract with Seattle Children's Hospital to promote universal newborn hearing screening in birthing hospitals.                                    |                          |    | X   |    |
| 3. Contract with Washington Sensory Disabilities Services to provide early intervention training to county representatives.                           |                          |    | X   |    |
| 4. Contract with a midwife to provide newborn hearing screening opportunities at three home birthing and/or play centers in King and Pierce Counties. |                          |    | X   |    |
| 5. Develop and implement a targeted communication/education plan about EHDDI follow-up services.  |                          | X  |     |    |

|     |  |  |  |  |
|-----|--|--|--|--|
| 6.  |  |  |  |  |
| 7.  |  |  |  |  |
| 8.  |  |  |  |  |
| 9.  |  |  |  |  |
| 10. |  |  |  |  |

#### **b. Current Activities**

The EHDDI tracking and surveillance system needs several enhancements to ensure reliable tracking for infant hearing screening, diagnosis, and referral to early intervention. Last fall, staff reviewed available hearing screening surveillance software and requested proposals from information technology vendors. The program selected a company specializing in data management solutions for newborn care. We are now working with that company to tailor their system to meet our needs.

EHDDI contracts with Seattle Children's and Washington Sensory Disabilities Services to provide training and technical assistance to hospital hearing screeners, audiologists, and early intervention providers. We have a new contract with a midwife to provide newborn hearing screening at three birthing and early play centers in King and Pierce Counties.

Using results from last year's parent survey, the EHDDI program is beginning work on a communications plan for targeted education about newborn hearing screening and follow-up to populations less likely to obtain an audiologic evaluation.

#### **c. Plan for the Coming Year**

The EHDDI program will analyze data from its tracking and surveillance system to determine whether the national 1-3-6 goals are being met and evaluate the efficiency of the EHDDI system. Washington State's screening data will be reported to the Centers for Disease Control and Prevention (CDC) for its annual survey.

EHDDI will continue to work on a possible linkage with the Infant Toddler Early Intervention Program (ITEIP) database. The programs have identified fields in the ITEIP database that may be used to link with patients in the EHDDI database. Staff will also analyze the completeness of data about hearing loss related intervention that Family Resources Coordinators (FRCs) report to the ITEIP database. These activities will occur in coordination with the development of EHDDI's new system for tracking screening and diagnostic evaluation results for infants, which should give the program more flexibility and opportunities when developing the linkage with ITEIP.

Using results from the analysis of the parent survey conducted last year, the EHDDI program will strategize and implement interventions for reducing the number of infants who do not have a reported audiologic evaluation after not passing their newborn hearing screen. The key findings that will influence the strategies are: 1) 45% of respondents with no record of an audiologic evaluation reported that their infant actually did receive an evaluation. 2) Infants of mothers with less than high school education or living in a rural area were less likely to have received an evaluation. 3) Younger mothers were less likely to recall receiving a referral for diagnostic evaluation

The EHDDI program will contract with Seattle Children's to provide technical assistance to birthing hospitals, educational outreach to audiology clinics, information on practices related to evaluating infants, and training for audiologists on how to use the EHDDI web application to report diagnostic results. The EHDDI program will also contract with WSDS to provide ongoing early intervention training to counties.

Infants delivered by midwives at home or in a birthing center often do not receive a newborn hearing screen, since midwives in these settings generally do not perform screens and the parent does not bring the infant to a hospital or clinic for a screen. In the coming year, the EHDDI

program will contract with a local midwife who will screen infants at three birthing and play centers in King and Pierce Counties. The EHDDI program expects that this will increase the percentage of newborns screened in this population from 15% currently to at least 25%.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>                             |
|---|-------------|-------------|-------------|-------------|---|
| Annual Performance Objective  | 6.2         | 5           | 5           | 4           | 4                                       |
| Annual Indicator  | 6.0         | 6.0         | 4.4         | 4.4         | 4.6                                     |
| Numerator   | 98000       | 97158       | 72158       | 72979       | 76954                                   |
| Denominator   | 1638000     | 1619803     | 1639962     | 1658605     | 1672915                                 |
| Data Source   |             |             |             |             | 2008 Washington State Population Survey |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |   |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                                   |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                             |
| Annual Performance Objective  | 4           | 3           | 3           | 3           | 3                                       |

**Notes - 2008**

PERFORMANCE OBJECTIVES: Decreasing targets were chosen due to the new law going into effect July 2007, granting children health insurance. Phase 2 of this law goes into effect in late 2009.

The data source is the 2008 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

**Notes - 2007**

No new data available for percent of uninsured kids. Rate same as reported last year.

**Notes - 2006**

PERFORMANCE OBJECTIVES: The 2006 data reflects the continuing trend based on data from 1998-2006. Decreasing targets were chosen due to the new law going into effect July 2007, granting children health insurance. Phase 2 of this law goes into effect in late 2009.

The data source is the 2006 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

**a. Last Year's Accomplishments**

In response to the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Improvement Summit held in September 2006, the Child and Adolescent Health section (CAH) worked with key organizations and agencies to implement a plan to improve use of EPSDT services. That plan included four key areas: pilot projects; quality improvement; health literacy, and incentives for a quality screening.

CAH worked to improve the use of EPSDT services and access to health insurance, with Department of Social and Health Services (DSHS) (Medicaid and child welfare), Washington affiliate of the American Academy of Pediatrics, Medicaid-contracted health plans, and other partners.

OMCH funded WithinReach's operation of the Family Health Hotline. This toll-free hotline and the Apple Health toll-free help line, also operated by WithinReach, provided callers with health information and referrals to health and social service programs and local resources. Operators assessed callers' need for health insurance for themselves and their children and referred them to health insurance programs.

In 2007 the state Legislature expanded health insurance coverage for children up to age 19 years. The law included provisions for care within a medical home. Eligibility is phased in by family federal poverty level (FPL) through 2009. The law also provided publicly funded insurance coverage to be available to children in families above FPL, through actual cost premiums. Outreach and education efforts were very effective in reaching not only newly eligible children, but also children who had previously been covered by Medicaid. This law went into effect in July 2007. Within the first three months nearly 9,000 children were enrolled for coverage. The Medicaid agency contracted with local health jurisdictions to provide outreach at the community level. Children with Special Health Care Needs (CSHCN) worked with an interagency committee to help define components of care and how Medicaid providers could be reimbursed for them.

OMCH worked with DSHS to provide outreach for the children's health insurance legislation. We assisted with a review of a request for proposals for a media outreach contract, assisted DSHS in contracting with local health jurisdictions for community outreach, and facilitated data sharing with the Women, Infants and Children Nutrition Program (WIC).

DOH participated on an interagency workgroup to enhance health literacy and identify performance indicators for health care in response to a state law increasing the number of children eligible for state-sponsored health insurance.

CAH funded two school-based health centers (SBHC) and eleven SBHC planning grants. SBHCs are required to establish linkages to the medical homes of students enrolled in the SBHC. SBHC strategies include, raising awareness of eligibility for state-sponsored health insurance, and assisting students to navigate health care systems. Due to statewide budget reductions, we were not able fund implementation for any of the SBHC planning grant communities.

CHILD Profile distributed the Healthy Kids Now! insert in its health promotion mailings to parents of children aged 3-5 years. The insert referred parents to the KIDS NOW toll-free phone number and the ParentHelp123.org website, a program of WithinReach that helps families assess their potential eligibility for state benefit programs, including Medicaid and Food Stamps, and fill out program applications on-line.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Coordinate with other key organizations and agencies to ensure that children, teens, and their families have access to health care services. |                          |    |     | X  |

|   |  |  |  |   |
|---|--|--|--|---|
| 2. Facilitate a state-level meeting to develop a plan to improve the use of the Medicaid Early Periodic Screening, Diagnostic, and Treatment program. |  |  |  | X |
| 3.  |  |  |  |   |
| 4.  |  |  |  |   |
| 5.  |  |  |  |   |
| 6.  |  |  |  |   |
| 7.  |  |  |  |   |
| 8.  |  |  |  |   |
| 9.  |  |  |  |   |
| 10.   |  |  |  |   |

#### **b. Current Activities**

CAH works with stakeholders to implement the plan to improve use of EPSDT, including: pilot projects, quality improvement, health literacy, and incentives for a quality screening.

DOH participates on an interagency group to enhance health literacy and identify performance indicators for quality health care.

OMCH funds WithinReach Family Health Hotline that provides health information and referrals to health and social services.

CHILD Profile distributes the Apple Health for Kids insert in health promotion mailings to parents of young children. It refers parents to the KIDS NOW toll- free number and the ParentHelp123.org website.

CAH funds two school-based health centers (SBHC) that coordinate with medical homes for students enrolled in the SBHC.

OMCH participates on interagency committees to expand health insurance coverage for all children. Coverage recently expanded to 300% of the federal poverty level (FPL). OMCH partners with DSHS to implement the outreach and education component of the children's health insurance legislation. CSHCN shares national materials from the Catalyst Center on the issues of the uninsured and underinsured children with special health care needs.

CSHCN funds the Adolescent Health Transition, Epilepsy, and Autism Projects to increase access to health care for youth with special needs transitioning into adulthood.

#### **c. Plan for the Coming Year**

CHILD Profile plans to continue distributing the Apple Health for Kids insert in its health promotion mailings.

CSHCN will continue to fund the University of Washington Adolescent Health Transition, Epilepsy, and Autism Projects to increase access to health care for youth with special needs transitioning into adulthood. CSHCN will continue to receive updates from DSHS Health and Recovery Services Administration (DSHS-HRSA) related to insurance options for children and youth with special health care needs in the state.

OMCH, including CSHCN, will continue to partner with DSHS to implement the outreach and education component of the children's health insurance legislation. We are working to link data sets at the state agency level. This will provide client listings for local health jurisdictions (LHJs) which they can use to contact families whose children are without health coverage. The LHJs will assist these families in enrolling their children for coverage. OMCH will disseminate information to partners, especially family organizations, to help them access the most current and useful

information about coverage options for their children. This will include information on the Office of Insurance Commissioner's new Statewide Health Insurance Benefits Advisors HelpLine.

CAH will continue to fund two school-based health centers (SBHC) that coordinate with medical homes for students enrolled in the SBHC. CAH will evaluate available funding to expand the number of centers.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>                                 |
|---|-------------|-------------|-------------|-------------|---|
| Annual Performance Objective  |             |             | 29          | 29          | 29  |
| Annual Indicator  | 29.3        | 29.2        | 28.9        | 29.4        | 30.4  |
| Numerator   | 25713       | 24679       | 25518       | 26081       | 29029                                       |
| Denominator   | 87693       | 84520       | 88312       | 88709       | 95359                                       |
| Data Source   |             |             |             |             | WA State Women Infants and Children Program |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |   |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final                                       |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                                 |
| Annual Performance Objective  | 29          | 29          | 29          | 29          | 29  |

**Notes - 2008**

PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2013. Maintaining current rates would be an improvement, showing that the rate of children becoming overweight is not increasing

The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2007. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

**Notes - 2007**

PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2012. Maintaining current rates would be an improvement, showing that the rate of children becoming overweight is not increasing.

The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2007. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

**Notes - 2006**

PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2012. Maintaining current rates would be an improvement, showing that children were not getting more overweight.

The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of children, ages 2 to 5 years, that receive WIC services during CY 2006. The denominator is number of children, ages 2 to 5 years, that receive WIC services during the reporting year.

#### **a. Last Year's Accomplishments**

CHILD Profile materials were mailed to parents of children aged birth to 6 years. The mailings contained age-appropriate nutrition information, including two nutrition brochures, and new, full-color growth and development charts. Physical activity information was incorporated into materials on child growth and development.

OMCH promoted nutrition and physical activity through partnerships with internal and external groups who work to promote healthy activities and prevent obesity in children and youth of all ages, their parents, and pregnant women.

Child care health consultants, OMCH, and the Washington State Child Health and Safety Advisory Committee gave presentations to child care providers on improving physical activity and nutrition. Two graduate nurse interns in OMCH worked on this issue, compiling and evaluating reviews of programs.

The new Bright Futures Guidelines emphasize the theme of maintaining healthy weight. Trainings on these guidelines were given within DOH and to external partners, including child care health consultants and MCH staff at local health jurisdictions.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Disseminate nutrition and physical activity information to parents statewide through CHILD Profile.  |                          |    | X   |    |
| 2. Coordinate with internal and external partners to promote nutrition and physical activity.   |                          |    |     | X  |
| 3. Provide training and consultation regarding nutrition and physical activity to child care providers through child care health consultants. |                          |    |     | X  |
| 4. Promote use of Bright Futures guidelines including Physical Activity and Nutrition.  |                          |    |     | X  |
| 5.  |                          |    |     |    |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

#### **b. Current Activities**

Child care health consultants recommend and help child care providers implement programs or activities to improve nutrition and physical activity for children and staff.

Bright Futures Guidelines, 3rd edition, is being integrated into the work of child care health consultants and home visitors, through training and guidance provided by OMCH.

CHILD Profile includes physical activity and nutrition information in its health promotion mailings.

Child care health consultants provide education and materials to child care providers on ways to increase physical activity. Intense nutrition consultation for infants and toddlers is part of the work of some child care health consultants. Nutrition/menu planning, and feeding issues are top topics discussed at child care health consultations. Consultants also participated in recommending food/nutrition rule changes to the child care licensing body.

The Early Childhood Comprehensive Systems grant partnership (Kids Matter) supports messages with early childhood partners to include obesity reduction strategies as part of their optimal health and child development activities to support the ultimate goal of health and school success.

### c. Plan for the Coming Year

CHILD Profile will continue including physical activity and nutrition information in its health promotion mailings.

CAH will explore working with partners on strategies to reduce obesity for young children. Bright Futures, 3rd edition, will be used more purposely in training new child care health consultants.

Kids Matter will support messages with early childhood partners to include obesity reduction strategies as part of their optimal health and child development activities to support the ultimate goal of health and school success.

### **Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>     |
|---|-------------|-------------|-------------|-------------|-----------------|
| Annual Performance Objective  |             |             | 10          | 9.1         | 9.1             |
| Annual Indicator  | 10.3        | 9.2         | 9.2         | 9.4         |                 |
| Numerator   | 8417        | 7602        | 7990        | 8359        |                 |
| Denominator   | 81715       | 82625       | 86845       | 88921       |                 |
| Data Source   |             |             |             |             | See field notes |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                 |
| Is the Data Provisional or Final?   |             |             |             | Final       |                 |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>     |
| Annual Performance Objective  | 9           | 9           | 8.9         | 8.9         | 8.8             |

#### **Notes - 2008**

No data available.

#### **Notes - 2007**

PERFORMANCE OBJECTIVES: Washington State is in the forefront of states in this measure. Looking at trending in the data, a 0.1% decrease every other year was chosen.

This indicator is based on the proportion of women reporting smoking in the last three months of pregnancy and is from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2008. The denominator are the number of women delivering babies during the year and are from the Washington State Department of Health Center for Health Statistics. The numerator is derived from these data.

#### **Notes - 2006**

PERFORMANCE OBJECTIVES: WA State is already among the leading states in the nation. Looking at data trends, a 0.1% decrease every other year was chosen.

This indicator is based on the proportion of women reporting smoking in the last three months of pregnancy and is from the Pregnancy Risk Assessment Monitoring System (PRAMS) for 2006. The denominator are the number of women delivering babies during the year and are from the Washington State Department of Health Center for Health Statistics. The numerator is derived from this data.

State performance measure 2 (Percent of pregnant women abstaining from smoking) is being discontinued in the future because the information is already captured within this national performance measure.

#### **a. Last Year's Accomplishments**

Maternal and Infant Health (MIH) informed providers of the Medicaid smoking cessation benefit to encourage providers to perform the smoking intervention with pregnant women and women of child-bearing age.

The required Maternity Support Services (MSS) smoking cessation performance measure interventions were conducted with MSS clients and documented in each client's chart by First Steps provider staff. Interventions included client centered education and referrals focused on tobacco cessation or reduction during pregnancy and reducing or eliminating prenatal and pediatric exposure to second hand smoke exposure. Billings were monitored for agency compliance in offering these interventions to all Medicaid clients.

Tobacco cessation during pregnancy trainings continued for over 100 First Steps providers, increasing compliance with performance measure requirements and supporting client centered interventions. Training for First Steps providers included new modules addressing relapse prevention and health disparities.

Pregnancy Risk Assessment Monitoring System (PRAMS) data measured smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities among groups.

MIH and partners informed First Steps and medical providers about the FAX Back Referral system and Quit Line to increase the use of the fax referral and other Quit Line services for pregnant women.

MIH and First Steps staff worked with other professionals to revise the Smoking Cessation during Pregnancy best practice booklet to improve the quality of smoking cessation intervention by medical professionals. Data about smoking and efforts to reduce smoking during pregnancy were compiled and shared with First Steps Providers. This data is used to ensure that quality improvement is measured.

WithinReach Family Health Hotline operators asked callers if anyone in the home smoked and offered referrals to the Quit Line. WithinReach included Quit Line materials in prenatal packets and child health packet through June 2008. WithinReach reported 1,274 callers to the Family Health Hotline who identified as smokers. Of these, 718 said they were pregnant and 715 said

there was a child in the home. There was some duplication in these counts as a caller could be both pregnant and have a child in the home. Of the 1,274 callers, 219 were referred to the state Quit Line.

OMCH assisted the Tobacco Program in implementing phase one of the CDC funded Quit Line enhancement project focused on pregnant women and relapse prevention. The purpose of this phase of the project was to conduct a Quit for You, Quit for Two social marketing campaign, increase public awareness about the benefits of quitting tobacco usage and exposure by pregnant and parenting women, and promote the Washington State Quit line.

OMCH assisted the Tobacco Program in implementing phase two of the CDC funded Quit Line enhancement project. The purpose of this phase was to conduct and follow up on surveys conducted with 138 First Steps provider staff. Results were used to evaluate and guide the implementation of a pilot project which evaluated the process and success of both training MSS staff to offer an incentive to over 100 pregnant women who smoke and measure the increase in the number of women willing to fill out the fax referral form and receive a call from the tobacco Quit Line.

The Tobacco Champion Project offered 187 First Steps providers additional motivational interviewing and systems change training. Local health jurisdictions received funds to provide smoking cessation services to pregnant women.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Promote the Medicaid Smoking Cessation benefit to providers.  |                          |    |     | X  |
| 2. Increase smoking cessation among Medicaid women by providing tobacco cessation intervention training to First Steps providers.  |                          |    | X   |    |
| 3. Provide culturally competent training and models of intervention on tobacco cessation to First Steps providers including new module addressing relapse prevention.  |                          |    |     | X  |
| 4. Collect and reference Pregnancy Risk Assessment Monitoring System (PRAMS) data to measure smoking rates before, during, and after pregnancy, quit rates, relapse rates, third trimester smoking trends, and disparities between groups. |                          |    |     | X  |
| 5. Inform and educate professionals about the FAX Back Referral program and other QUIT Line services.  |                          |    |     | X  |
| 6. Revise best practice guide for smoking cessation for medical providers.   |                          |    |     | X  |
| 7. Share tobacco data with First Steps providers and perinatal providers.  |                          |    |     | X  |
| 8. Through WithinReach, refer callers with tobacco in their home to the Quit Line as appropriate.  |                          |    | X   |    |
| 9. Work with the Tobacco Program to implement their CDC funded Quit Line enhancement project that focuses on pregnant women and relapse prevention.  |                          |    | X   |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

MIH continues to inform providers of the Medicaid smoking cessation benefit

MIH and its partners provide technical assistance to First Steps providers including compliance with the First Steps Tobacco Cessation during Pregnancy Performance Measure. MIH informs

First Steps and medical providers about the FAX Back Referral system to increase use of the Washington State Quit Line services targeting pregnant and parenting women.

MIH is revising a best practice guide for smoking cessation to medical providers and will publish this via internet.

WithinReach asks callers if there is a smoker in the home and offers Quit Line referrals.

OMCP is assisting the Tobacco Program in phase three of the CDC funded Quit Line enhancement project. Phase Three will evaluate data from Phases One and Two. Phase three will also offer incentives to over 500 pregnant women who smoke to encourage them to fill out the fax referral form and receive a call from the Tobacco Quit Line.

Participating agencies will receive a package with fax referral forms and client incentives. Upon referral, the client is offered enrollment in the free, pregnancy-specific tobacco cessation program offered by the quit line.

### **c. Plan for the Coming Year**

Budget cuts to the tobacco program have been legislated and are scheduled to be implemented in this budget year. This may negatively impact the smoking trend. Issues that may positively impact smoking rates are the declining economy and extra taxes placed on tobacco products.

MIH will continue to use PRAMS data to track smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities among groups.

MIH will continue to inform providers of the Medicaid smoking cessation benefit for all Medicaid Medical Program participants. MIH will also continue to disseminate the updated best practice guide for smoking cessation to medical providers via internet.

WithinReach will ask callers if there is a smoker in the home and offer Quit Line referrals.

MIH and partners will continue to inform First Steps and medical providers about the FAX Back Referral system and Quit Line to increase the use of the fax referral and other Quit Line services for pregnant women.

MCH will continue to partner with the Tobacco Program to implement Tobacco Cessation during Pregnancy Trainings for over 100 First Steps Providers, increasing compliance with the performance measure requirements and supporting client centered interventions. However, with cuts to the First Steps program, fewer women are expected to be served.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>              | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>     |
|---|-------------|-------------|-------------|-------------|-----------------|
| Annual Performance Objective                              | 8.4         | 8.9         | 8.9         | 8.8         | 8.7             |
| Annual Indicator  | 10.2        | 9.1         | 8.5         | 8.0         |                 |
| Numerator   | 45          | 41          | 39          | 40          |                 |
| Denominator   | 442824      | 450402      | 459182      | 497786      |                 |
| Data Source   |             |             |             |             | See field notes |
| Check this box if you cannot report the numerator because |             |             |             |             |                 |

|  |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|
| 1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?  |             |             |             | Final       | Provisional |
|  | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| Annual Performance Objective   | 7.9         | 7.8         | 7.7         | 7.6         | 7.5         |

#### Notes - 2008

No data available.

#### Notes - 2007

PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are subject to considerable variance and trends are based on many years of data, so future targets may not appear to align with the most recent results. The 2007 95% confidence interval ( 5.7, 10.9) includes the performance objective. After discussions with program and assessment staff we decided to revise the performance objective downward based on the data from the last four years. Because of the small numbers, the rates are highly variable. A conservative annual decrease of 0.1 in the rate/year was chosen.

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

#### Notes - 2006

PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are very variable and trends are based on many years of data, so future targets may not appear to align with the most recent results. The 95% confidence interval ( 6.1, 11.6) which includes the performance objective. Because of the small numbers, the rates are highly variable. A conservative annual decrease of 0.1 in the rate/year was chosen.

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

#### a. Last Year's Accomplishments

OMCH worked with the Emergency Medical Services, Trauma Systems, and Injury Prevention sections, in the DOH Office of Community Health Systems (OCHS) on common priorities, including youth suicide prevention.

OMCH worked with OCHS to implement the Youth Suicide Prevention Plan to reduce teen suicide. Plan activities focus on awareness, early intervention skills, and engaging communities to address suicide through prevention, early intervention, and skill building. We continue to work to expand statewide partnerships.

OCHS implemented a grant from the Substance Abuse Mental Health Services Administration (SAMHSA) for federal youth suicide prevention support. These funds augmented state funded efforts and supported work in more targeted communities including Native American Tribes,

homeless youth, and college campuses. The grant also supported updating the Youth Suicide Prevention Plan that was created in 1995.

OMCH worked with OCHS and other stakeholders to disseminate the Washington State Injury & Violence Prevention Guide. Suicide is a focus area in the Guide.

OMCH conducted surveillance of suicide deaths through local Child Death Review (CDR) teams. OMCH administered Washington State participation in a multi-state CDR database. The database includes youth suicides and strategies recommended by local CDR teams for youth suicide prevention. OMCH provided technical assistance to CDR teams regarding use of the database, best practices, and effective team practices. CDR teams made policy and practice recommendations to local service providers and policy makers to reduce the rate of unexpected child and youth deaths, including strategies for preventing youth suicide.

OMCH promoted the use of the Harborview Injury Prevention Resource Center web-based decision-making tool. The tool was refined to assist CDR teams in reviewing promising practices, strategies, and evidence-based interventions. The website includes interventions specific to preventing youth suicide. <http://depts.washington.edu/cdreview>.

**Table 4a, National Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Work with DOH Office of Community Health Systems to support youth suicide prevention.   |                          |    |     | X  |
| 2. Conduct surveillance of suicide deaths through Child Death Review (CDR) and disseminate data and prevention strategies.   |                          |    |     | X  |
| 3. Administer Washington State participation in multi-state CDR database.  |                          |    |     | X  |
| 4. Promote training and strategies of suicide prevention to stakeholders.  |                          |    | X   |    |
| 5. Participate in the dissemination of the State Injury Prevention & Violence Prevention Guide which includes a chapter on suicide.  |                          |    |     | X  |
| 6. Promote use of the Harborview Injury Prevention Resource Center web-based tool that describes best practices and recommendations for injury prevention, including youth suicide prevention. |                          |    | X   |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

The overall downward trend in youth suicide rates continues.

OCHS leads implementation of statewide youth suicide prevention activities. OMCH promotes programmatic activities, provides linkages to other related activities, and provides critical data sources that can lead to a reduction in the teen suicide rate. OMCH provided data and input for the revision of the State Youth Suicide Prevention Plan.

Recommendations from the evaluation of the Youth Suicide Prevention Program are incorporated into program planning to the extent possible. Results show that youth who were aware of suicide prevention messages in schools were more likely to seek help for a friend than those who were unaware of these messages. The Youth Suicide Prevention Program provides schools with a way

to share these messages with youth.

The 2008 Healthy Youth survey includes questions on depression, suicidal ideation, suicide plans, and suicide attempts.

OMCH conducts surveillance of suicide deaths through the local CDR teams. OMCH administers Washington State participation in a multi-state CDR database and is working with the National Center for CDR to add the data from the old Washington State database into the multi-state database. OMCH provides technical assistance to CDR teams regarding use of the database, best practices, and effective team practices.

OMCH staff works with OCHS on common priorities. The State Injury and Violence Prevention stakeholders help market the plan and implement strategies.

### **c. Plan for the Coming Year**

OCHS will continue to lead implementation of statewide youth suicide prevention activities. OMCH will provide support by promoting programmatic activities, providing links to other related activities, and providing critical data sources that can lead to a reduction in the teen suicide rate.

Recommendations from the Youth Suicide Prevention Program evaluation will be incorporated into program planning to the extent possible.

OMCH will work with the 18 current local CDR teams and any additional teams that are formed. These teams make policy and practice recommendations to reduce the rate of child and youth deaths, including strategies for preventing suicide. Local teams will continue to add data to the multi-state database.

OMCH will implement legislation passed in 2009 requiring DOH to assist CDR coordinators with data collection, provide technical assistance, and encourage communication among CDR teams. No state funds were allocated for this work. The legislation specified that these activities be conducted using only federal and private funds.

OMCH will work with OCHS on activities that are common priorities. The State Injury and Violence Prevention Guide and updated State Youth Suicide Prevention Plan will be promoted and implemented. Community partners will help market the plan and implement its strategies.

OMCH will implement the 2010 Healthy Youth Survey.

### **Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b>   | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>     |
|--|-------------|-------------|-------------|-------------|-----------------|
| Annual Performance Objective   |             | 85          | 86          | 87          | 86.1            |
| Annual Indicator   | 86.1        | 87.8        | 85.9        | 85.8        |                 |
| Numerator  | 683         | 604         | 709         | 774         |                 |
| Denominator  | 793         | 688         | 825         | 902         |                 |
| Data Source  |             |             |             |             | See field notes |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years |             |             |             |             |                 |

|  |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|
| is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?  |             |             |             | Final       |             |
|  | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b> |
| Annual Performance Objective   | 86.2        | 86.2        | 86.3        | 86.3        | 86.4        |

#### **Notes - 2008**

No data available.

#### **Notes - 2007**

PERFORMANCE OBJECTIVES: A combination of trend analyses and discussions were used to create the future objectives. The number of tertiary care hospitals has increased over time leading to improvements in this indicator, but is not expected to increase further. Therefore, an increase of 0.1 percent every two years was chosen.

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files

#### **Notes - 2006**

PERFORMANCE OBJECTIVES: A combination of trend analyses and discussions were used to create the future objectives. The number of tertiary care hospitals has increased over time leading to improvements in this indicator, but is not expected to increase further. Therefore, an increase of 0.1 percent every two years was chosen.

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files

#### **a. Last Year's Accomplishments**

The Regional Perinatal Networks (PRN) implemented state and regional quality improvement projects aimed at improving poor pregnancy outcomes.

OMCH contracted with local health jurisdictions (LHJs) to provide maternal and child health services, which included routine referrals and assistance in linking with Medicaid and prenatal care.

OMCH Assessment monitored and reported the delivery sites of very low birth weight babies. Some findings included: 1) the number of level 3 facilities increased, 2) the number of babies born very low birth weight increased at a greater rate than overall births, 3) 35% of very low birth weight babies born at level 1 and 2 facilities, and 21% of very low birth weight babies born at level 3 facilities died.

In March, 2008 OMCH Assessment presented data to the PRN coordinators. They discussed the characteristics of very low birth weight babies born at level 3 versus non-level 3 facilities. In 2006 there were 871 very low birth weight babies born in Washington; 95% were to Washington residents (827) and 74% were singletons. Very low birth weight births accounted for about 43% of infant deaths in Washington. Eighty-six percent of very low birth weight infants were born at Level 3 perinatal facilities. Some risk factors for very low birth weight were reported more among infants born at Level 3 facilities. These included pregnancy hypertension, preterm premature rupture of membranes, and multiple births. Very low birth weight infants born at Level 1 or Level 2 facilities were more likely to have mothers who were young, smoked, lacked prenatal care, or who had precipitous labor. Following the presentation the PRN coordinators discussed next steps and decided to present the findings to regional hospitals in order to increase staff awareness.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Fund Regional Perinatal programs to coordinate and implement quality improvement projects to improve pregnancy outcomes statewide.                             |                          | X  |     |    |
| 2. Fund local health jurisdictions (LHJ) to provide referrals to prenatal care if clients are not already enrolled and to support women to stay in prenatal care. |                          | X  |     |    |
| 3. Monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities.                                 |                          |    | X   |    |
| 4.  |                          |    |     |    |
| 5.  |                          |    |     |    |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

**b. Current Activities**

OMCH Assessment continues to monitor and report the delivery sites of very low birth weight babies.

PRN is forming local perinatal advisory committees to develop models for regional quality improvement to promote high quality perinatal and neonatal services. They are also developing a quality improvement project aimed at improving access to early prenatal care. In addition, the Northwest Perinatal Regional Network is expanding the consortium created in 2008 to collect in depth outcome data for very low birth weight infants born in Washington. Ten hospitals are in the consortium and the remaining hospitals are being recruited. Approximately 40% of the births in Washington State occur at the hospitals currently participating in the consortium.

**c. Plan for the Coming Year**

OMCH Assessment will continue to monitor and report the delivery sites of very low birth weight babies. Rural Washington State has had an increase of close to 10% in overall birthrate in the last 3 years. OMCH believes that this increase in areas where pregnant women must travel to level 3 facilities, has directly impacted the percent of very low birth weight infants delivered at non level 3 facilities.

The Perinatal Advisory Committee will continue to explore the following questions: 1) Can more be done to increase the proportion of very low birth weight infants born at Level 3 facilities in Washington? 2) Can mothers be educated to recognize signs of pre-term labor? 3) Can women with a history of preterm labor develop a plan to get to a Level 3 facility if pre-term labor begins?

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---------------------------------------|------|------|------|------|------|
| Annual Performance Objective          | 85.1 | 83   | 80   | 81   | 81   |
| Annual Indicator                      | 79.6 | 79.2 | 78.5 | 76.3 |      |

|   |             |             |             |             |                 |
|---|-------------|-------------|-------------|-------------|-----------------|
| Numerator   | 53367       | 54648       | 59518       | 61938       |                 |
| Denominator   | 67048       | 69038       | 75853       | 81187       |                 |
| Data Source   |             |             |             |             | See field notes |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |                 |
| Is the Data Provisional or Final?   |             |             |             | Final       |                 |
|   | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>     |
| Annual Performance Objective  | 77          | 77          | 77          | 78          | 78              |

#### Notes - 2008

Data are not available for 2008.

#### Notes - 2007

PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2007, 8.7% of the data was missing for this measure. This is, however, an improvement over past year's percentages

Trend analyses based on data from 2003-2007 indicate a continued decrease in this measure. Additionally, there is a large disparity by Medicaid status. 65.3% of women receiving Medicaid received care beginning in the first trimester compared to 86.6% of women not receiving Medicaid (source First Steps Data Base, Washington State Department of Social and Health Services). The apparent and sustained decrease in the measure has led program staff to believe that decreasing the target to reflect recent data and holding this rate steady is the optimal outcome which can be achieved in the short term given recent cuts to the First Steps program and a lack of availability of providers to take on additional Medicaid patients in some regions of the state. It is hoped that future economic conditions will facilitate a return to a positive trend in this measure and this is indicated in an increase of 1% and its maintenance in the 2012-2013 period.

Further, the National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information....Accordingly, prenatal care data for the two revisions are not comparable." As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on five years' worth of data (2003-2007).

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded.

#### Notes - 2006

PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2006, 12.7% of the data was missing for this measure.

Trend analyses based on data from 2003-2007 indicate a decrease in this measure. Additionally, there is a large disparity by Medicaid status. 68.4% of women receiving Medicaid received care beginning in the first trimester compared to 87.7% of women not receiving Medicaid. We are working closely with our partners in the Department of Social and Health Services to better

understand the causes of both the disparity and decline in 1st trimester prenatal care and have jointly developed these targets.

Further, the National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information....Accordingly, prenatal care data for the two revisions are not comparable." As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on three years' worth of data (2003-2005).

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded.

#### **a. Last Year's Accomplishments**

OMCH contracted with local health jurisdictions (LHJs) to provide maternal and child health services, which included routine referrals and assistance in linking with Medicaid and prenatal care.

Prenatal care usage data was monitored, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee (PAC). Overall in Washington State, there appeared to be a downward trend in first trimester care beginning in 2003, especially for low-income women and in specific localities. The disparity in first trimester prenatal care access between Medicaid and Non-Medicaid women appeared significant. In 2003, Washington State was one of the first states to use the new birth certificate. With 20% missing data for entry into prenatal care the first couple of years, and only 3 data points, we were not ready to declare a trend.

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 76.4% in 2007. In other words, the number of women in Washington entering prenatal care in the first trimester has decreased by almost 5% in the past four years, with a larger decrease among women receiving Medicaid. However, in the same timeframe the percentage of women entering prenatal care in the 2nd and 3rd trimesters have both increased, indicating a gradual shifting into care later in pregnancy.

The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. During this period 6,593 pregnant women called the FHH. Of these callers, 1,735 were already receiving prenatal care.

In Pierce County a contractor provided outreach to African American women to encourage early entry into prenatal care and enrollment in Maternity Support Services (MSS). The contractor attended community events, church sponsored events and other community meetings to reach this population. Results from these efforts included an increased presence and partnership with the African American community in Pierce County. Feedback from community members led to piloting a new way to work with this community.

Data reports about the declining rates of first trimester prenatal care were used during meetings to raise awareness of this issue with the following stakeholders: First Steps providers, the Perinatal Advisory Committee, Tribes and urban Indian organizations, American Indian Health Commission, local health jurisdictions, and other groups working on access issues. OMCH partnered with Department of Social and Health Services (DSHS) Medicaid program to assess barriers for women receiving Medicaid.

First Steps database staff disseminated a County Profiles report which focused on first trimester entry rates. Findings were presented to stakeholder groups. Communities with the lowest rates of first trimester prenatal care, and greatest disparity between Medicaid and Non-Medicaid births

were targeted. Community stakeholder meetings were convened to gather information about issues affecting entry into prenatal care.

**Table 4a, National Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Provide outreach and education through WithinReach to pregnant women to increase early enrollment in prenatal services.  |                          |    | X   |    |
| 2. Refer women to Maternity Support Services (MSS) providers for prenatal care if they are not already enrolled and support women to stay in prenatal care.       |                          | X  |     |    |
| 3. Fund local health jurisdictions (LHJ) to provide referrals to prenatal care if clients are not already enrolled and to support women to stay in prenatal care. |                          | X  |     |    |
| 4. Share prenatal care usage data with MSS and perinatal providers.   |                          |    |     | X  |
| 5. Promote early prenatal care and MSS enrollment to African American women.  |                          | X  |     |    |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

#### **b. Current Activities**

OMCH contracts with Tacoma Pierce County Health Department (TPCHD) to provide outreach for First Steps services to African American pregnant women. TPCHD will pilot a program using health ministers to improve referrals to the First Steps program.

OMCH contracts with local health jurisdictions to provide maternal and child health services, including referrals and linkage to prenatal care. We also monitor prenatal care access data and distributed it to partners.

OMCH is working with Clark, Pierce and Walla Walla counties on projects related to prenatal care access. Our goal is to increase the percent of pregnant women who enter prenatal care in the first trimester. These projects place a special emphasis is on African American, Native American, low income and teenage pregnant women.

OMCH and First Steps staff will continue to present findings to stakeholder groups and gather information using community meetings. Communities with the lowest rates of first trimester prenatal care, and/or greatest disparity between Medicaid and Non-Medicaid paid births will be targeted.

The WithinReach Family Health Hotline continues to refer pregnant women to benefit programs and provide information about prenatal care services. OMCH is working with WithinReach to improve awareness of the importance of prenatal care and to help pregnant women access First Steps.

#### **c. Plan for the Coming Year**

OMCH will continue to contract with local health jurisdictions to provide maternal and child health services, which includes routine referrals and assistance linking with Medicaid and prenatal care.

We will continue to monitor prenatal care data and distributed it to First Steps providers, include it in the Perinatal Indicators Report, and share it with the Perinatal Advisory Committee. MIH will continue to work with communities with the lowest rates of first trimester prenatal care, and/or greatest disparity between Medicaid and Non-Medicaid paid births.

OMCH will continue working with Clark, Pierce, and Walla Walla counties on projects related to prenatal care access. The goal of these activities is to increase the percentage of pregnant women who enter prenatal care in the first trimester. Quality improvement processes will include working with local stakeholders on an intervention and evaluation plan. These projects will focus on pregnant women who are African American or Native American and/or teenage or low income.

OMCH will continue to contract with the Tacoma Pierce County Health Department to provide outreach and linkage to First Steps services and disperse culturally appropriate health messages to pregnant women who are African American and Medicaid-eligible. An evaluation plan will be implemented and strategies for sustaining the intervention will be explored. This is part of a focused effort to decrease poor pregnancy outcomes for which African American Medicaid-eligible clients are at disproportionately increased risk.

OMCH will develop community-specific strategies to address issues as they are identified. Examples of strategies could include working with: 1) community service organizations and health plans to increase rapid linkage, enrollment, and outreach to pregnant women 2) DOH Rural Health Program to recruit obstetric care providers, and 3) DSHS Health and Recovery Services Administration provider enrollment field staff to help existing providers address billing issues.

The WithinReach Family Health Hotline will continue to refer pregnant women to benefits programs including Medicaid and to provide information about prenatal care services. WithinReach and DOH are working on new activities to increase awareness about the importance of prenatal care and the availability of First Steps and other programs for pregnant women. These activities include enhancing the information for pregnant women on WithinReach's ParentHelp123.org website, implementing an on-line tool that pregnant women can use to find First Steps providers near them, educating health care providers about the services WithinReach can provide to their clients, and improving the information about First Steps given out on Family Health Hotline. They are also doing research to identify possible outreach methods for future use.

## D. State Performance Measures

**State Performance Measure 1:** *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004        | 2005        | 2006        | 2007        | 2008            |
|---------------------------------------|-------------|-------------|-------------|-------------|-----------------|
| Annual Performance Objective          | 52.8        |             | 52          | 52          | 52              |
| Annual Indicator                      | 49.5        | 51.7        | 51.0        | 50.0        |                 |
| Numerator                             | 52596       | 55011       | 56923       | 56835       |                 |
| Denominator                           | 106283      | 106427      | 111635      | 113656      |                 |
| Data Source                           |             |             |             |             | See field notes |
| Is the Data Provisional or Final?     |             |             |             | Final       |                 |
|                                       | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>     |
| Annual Performance Objective          | 51          | 51          | 51          | 51          | 51              |

**Notes - 2008**

No data are available for 2008.

#### **Notes - 2007**

The numerator for this measure is derived from the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey \*(resident live births + reported resident abortions). The denominator for this measure is the number of resident live births + reported resident abortions. Birth and abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2007. PRAMS 2007 data are used.

Given three years of a slight, but steady downward trend it was decided to lower the annual performance objective by one percent through 2013.

#### **Notes - 2006**

**PERFORMANCE OBJECTIVES:** The unintended pregnancy rate in Washington has been stable for several years despite decreases in the abortion rate and declines in teen pregnancy rates.. Given the stability of this measure, the development of other family planning measures which may have more information is being investigated.

This numerator for this measure is derived from the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey \*(resident live births + reported resident abortions). The denominator for this measure is the number of resident live births + reported resident abortions. Birth and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2006. PRAMS 2006 data are used.

#### **a. Last Year's Accomplishments**

In 2006, approximately 37% of Washington State births resulted from unplanned pregnancies [Pregnancy Risk Assessment Monitoring System (PRAMS) data]. The rate is significantly higher for women receiving Medicaid (51%) than for women not receiving Medicaid (24%). However, Medicaid births from unintended pregnancies have significantly decreased from 56% in 2000 to 51% in 2005. The unintended pregnancy rate was approximately 50% in 2007. This rate includes unplanned births and all abortions. The unintended pregnancy rate has remained constant in Washington State for many years.

Two hundred sixty-seven (267) callers to the Family Health Hotline, which provides family planning information and referral assistance, received family planning information. The Take Charge toll free line, funded by the Department of Social and Health Services (DSHS), provides family planning referral assistance and was accessed by 3,531 callers. Callers to these two lines were given information and referrals related to their family planning need.

Maternity Support Services (MSS) Family Planning training was available through web based training modules for all new MSS providers. Our goal was to increase provider access to training about family planning interventions for MSS clients. MSS family planning performance measure billings were monitored for agency compliance in offering family planning education to all Medicaid clients.

Updated PRAMS data on unintended pregnancy was incorporated into the Perinatal Indicators Report and shared with the Perinatal Advisory Committee (PAC). OMCH also made this data available via the internet to First Steps agencies and local health jurisdictions.

Every family that gave birth in Washington State received CHILD profile mailings. CHILD Profile included a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing was also placed in the 3-month letter. These letters were sent to women delivered a baby in Washington State during the specified time period.

In an effort to provide medical professionals with a good source of information to share with patients about birth control options, OMCH continued to distributing a birth control brochure to providers.

OMCH explored collaborative activities with the Department of Corrections related to reproductive health education and service linkage for female inmates in preparation for their release. OMCH worked with DSHS to expedite services to this population upon release.

**Table 4b, State Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Increase referrals to family planning services and use of birth control.                      |                          | X  |     |    |
| 2. Provide Family Planning training to MSS agencies.   |                          |    |     | X  |
| 3. Promote Medicaid Take Charge Program to increase family planning services for men and women.  |                          | X  |     |    |
| 4. Analyze reports on MSS Family Planning performance measure.                                   |                          |    |     | X  |
| 5. Provide birth control education and referral to family planning services through WithinReach. |                          |    | X   |    |
| 6.   |                          |    |     |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

The WithinReach Family Health toll-free line provides family planning information and referral assistance. The Take Charge toll free line, funded by DSHS will provide family planning referral assistance.

Updated PRAMS data on unintended pregnancy will be incorporated into the Perinatal Indicators Report, shared with the Perinatal Advisory Committee, and made available via the internet to First Steps agencies and local health jurisdictions.

CHILD Profile includes a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing is in the 3-month letter. The letters are sent to women who have delivered baby in Washington State during the specified time period.

OMCH continues to disseminate a birth control brochure to providers.

OMCH continues collaborative activities with the Department of Corrections related to reproductive health education and service linkage for female inmates in preparation for their release. OMCH will work with DSHS to expedite services to this population upon release.

#### **c. Plan for the Coming Year**

The WithinReach Family Health toll-free line will provide family planning information and referral assistance. The Take Charge toll free line, funded by DSHS, will provide family planning referral assistance.

Updated PRAMS data on unintended pregnancy will continue to be incorporated into the Perinatal Indicators Report, shared with the Perinatal Advisory Committee, and made available via the internet to First Steps agencies and local health jurisdictions.

CHILD Profile will continue to include messages about birth spacing and family planning in the 30-day postpartum letter and a message about birth spacing in the 3-month letter. The letters will be sent to women who will deliver a baby in Washington State during the specified time period.

OMCH will continue to disseminate the new birth control brochure to providers.

OMCH will continue to collaborate with the Department of Corrections on reproductive health education and service linkage for female inmates in preparation for their release. OMCH will continue to work with DSHS to expedite services to this population upon release.

**State Performance Measure 5:** *Promote the use of Bright Futures materials and principles by health, social service, and education providers in Washington State.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b> | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>                                  |
|--|-------------|-------------|-------------|-------------|--|
| Annual Performance Objective                 |             |             | 70          | 85          | 95   |
| Annual Indicator                             |             | 40          | 65          | 80          | 90   |
| Numerator                                    |             |             |             |             |  |
| Denominator                                  |             |             |             |             |  |
| Data Source                                  |             |             |             |             | WA State Child and Adolescent Health Section |
| Is the Data Provisional or Final?            |             |             |             | Final       | Final  |
|  | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                                  |
| Annual Performance Objective                 | 100         | 100         | 100         | 100         | 100  |

**Notes - 2008**

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State.

The following new benchmarks have been attained:

**Year 4**

- Develop plan for ongoing professional oral health trainings, based on the evaluation.
- Assess Bright Futures activities to date and revise the plan in order to continue health promotion activities for the MCH population.

These data are provided by the Office of Maternal and Child Health, Child and Adolescent Health Section of the Washington State Department of Health, Division of Community and Family Health.

**Notes - 2007**

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each

year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State. The following new benchmarks have been attained:

#### Year 3

- Conduct trainings or develop curricula/materials according to needs identified in assessment.
- Evaluate Bright Futures oral health trainings.
- Disseminate findings from Foster Parent Mental Health project

#### Notes - 2006

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State. The following benchmarks have been attained.

#### Years 1 and 2

- Form internal (DOH) Bright Futures working/advisory group.
- Plan for establishing inter-agency Bright Futures group—including for example schools or OSPI, American Academy of Pediatrics national and state chapters, family practitioners, Medicaid (DSHS), health plans
- Provide support and technical assistance to groups of professionals recently trained in use of Bright Futures: the school nurse corps supervisors, early childhood providers participating in Bright Futures in Early Childhood.
- Develop plan for assessment of current use of Bright Futures by health, social service and education providers in the state.
- Develop plan for using Bright Futures Oral Health in statewide trainings.
- Begin implementation of the grant-funded project to train foster families in mental health issues using Bright Futures.
- Disseminate findings/successes/lessons learned from Bright Futures in Early Childhood Project.
- Begin assessment of the current use of Bright Futures by Washington State providers.
- Begin assessment of the current use of Bright Futures by Washington State providers.
- Begin assessment of the need for Bright Futures trainings among professionals across the state.
- Continue Foster Parent Mental Health training.
- Collaborate or coordinate with other DOH groups such as Physical Activity and Nutrition, or STEPS, to promote Bright Futures.
- Implement Bright Futures Oral Health trainings.
- Develop materials for trainings of health, education and social service providers.

-

#### a. Last Year's Accomplishments

This measure was chosen because Bright Futures is a tool and a best practice for increasing quality of health care and health education for children and families. By using and promoting Bright Futures, MCH is furthering the goals of MCH Priorities: 1) Adequate nutrition and physical activity, 3) Optimal mental health and healthy relationships, 6) Healthy physical growth and cognitive development, 8) Access to preventive and treatment services, and 9) Quality screening, identification, intervention and care coordination.

The toolkit, Bright Futures Guidebook for Early Childhood Care and Education, was distributed statewide and nationally. Guidebooks were sent out from DOH in response to individual requests, and were distributed at conferences and meetings. The guidebooks are also given to new child care health consultants at their orientations.

New trainings and work with school nurse training teams have been on hold due to decreases in the federal MCH Block Grant. These activities were contracted through University of Washington (UW) and the funding decrease led to the cancellation of that contract.

The new Bright Futures Guidelines were presented to OMCH staff to promote awareness of them. They are available as a resource at OMCH.

OMCH staff provided information to early childhood professionals about the new edition of Bright Futures, especially the congruence with American Academy of Pediatrics periodicity schedule. Trainings and presentations will emphasize the themes of mental health promotion and maintaining healthy weight.

CAH staff fostered integration of Bright Futures in Early Childhood as part of the Early Childhood Comprehensive Systems (ECCS) grant and the Kids Matter partnership and strategic plan/framework that was developed through ECCS.

The Washington Bright Futures website was a resource for DOH and the public about Bright Futures activities.

The Bright Futures Oral Health Project was reviewed by UW and DOH.

**Table 4b, State Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Provide training on the use of the Bright Futures guidelines and materials.   |                          |    |     | X  |
| 2. Collaborate with DOH Oral Health staff to develop a consistent oral health message using Bright Futures.  |                          |    | X   |    |
| 3. Build and maintain Washington Bright Futures Website.   |                          |    |     | X  |
| 4. Present Bright Futures projects at state and national conferences.  |                          |    |     | X  |
| 5. Use Bright Futures guidelines and principles in trainings for child care health consultants, both initial orientation and continuing education. |                          |    |     | X  |
| 6.   |                          |    |     |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

#### **b. Current Activities**

CAH is using the third edition of Bright Futures Guidelines to evaluate existing materials, such as the Early Childhood Guidebook, and training modules for child care health consultants, for possible revision. CAH will continue to train child care health consultants, and possibly child care providers, on the DOH Bright Futures Oral Health curriculum.

The Bright Futures Oral Health Project materials are being finalized. Trainings will be planned and implemented.

Bright Futures is presented to child care health consultants as the standard for well-child care, and they pass this information on to child care providers and the public. The American Academy of Pediatrics Bright Futures books are recommended, and the Washington State Early Childhood Toolkit is given, to child care health consultants at their orientations.

### c. Plan for the Coming Year

Child care health consultants (CCHC) will be given more focused training on the national Bright Futures guidelines and the Early Childhood Project in Washington State. The CCHC coordinator will do this through a statewide conference or more local trainings.

CAH plans to increase outreach to health care providers about the use of Bright Futures Guidelines in well-child care. This will include outreach both during initial training and as part of continuing education for physicians, nurse practitioners, and other primary care providers.

### State Performance Measure 6: *Percent of children 6-8 years old with dental caries experience in primary and permanent teeth.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004        | 2005        | 2006        | 2007        | 2008                               |
|---------------------------------------|-------------|-------------|-------------|-------------|------------------------------------|
| Annual Performance Objective          |             |             | 52.2        | 58          | 57                                 |
| Annual Indicator                      | 55.6        | 59.0        | 59.0        | 59.0        | 59.0                               |
| Numerator                             | 136345      | 145873      | 147801      | 147801      | 151331                             |
| Denominator                           | 245224      | 247243      | 250511      | 250511      | 256493                             |
| Data Source                           |             |             |             |             | Washington State 2005 Smile Survey |
| Is the Data Provisional or Final?     |             |             |             | Final       | Final                              |
|                                       | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                        |
| Annual Performance Objective          | 56          | 55          | 54          | 53          | 52                                 |

#### Notes - 2008

PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2013 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for the indicator for 2008. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

#### Notes - 2007

PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2012 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for 2007. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

#### Notes - 2006

**PERFORMANCE OBJECTIVES:** There are only two years of data available since the Smile Survey is administered every five years. As more data becomes available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2011 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there is no new data for 2006. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

#### **a. Last Year's Accomplishments**

OMCH implemented a statewide surveillance system to monitor oral health indicators. The Impact of Oral Disease on the Lives of Washingtonians-The Washington State Oral Disease Burden Document, was published in July 2007. The burden document was disseminated in the state through an official press release.

Oral Health program staff implemented an OMCH Oral Health Strategic Plan, which is aimed at integrating oral health activities into the six OMCH Sections (Assessment, Maternal and Infant Health, Child and Adolescent Health, Immunizations CHILD Profile, Genetics, and Children with Special and Health Care Needs).

OMCH Oral Health Program worked with partners to tailor the Bright Futures Oral Health and Tooth Tutor messages to different MCH-related programs including WIC, Head Start, and First Steps. These materials are also available online.

OMCH implemented the activities in the Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs. They used Health Resource and Service Administration Targeted State Oral Health Service Systems (TOHSS) grant funds and worked with partners to implement this plan. OMCH organized two regional forums in August 2008 to bring partners together to implement the TOHSS grant.

OMCH Oral Health Program supports a strong state oral health coalition and 32 local oral health coalitions, which unite the different county and oral health stakeholders.

OMCH Oral Health Program funded local oral health programs to educate families and MCH related programs. Parents of children aged birth-6 years received CHILD Profile letters that include information on oral health.

OMCH Oral Health Program maintained a website with information on oral health and access to dental care.

**Table 4b, State Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Tailor Bright Futures Oral Health and Tooth Tutor messages to different MCH-related programs (WIC, Head Start, First Steps, etc.) and upon revision make available online in a fact sheet format. |                          |    |     | X  |
| 2. Implement the Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs.  |                          |    | X   |    |
| 3. Organize two regional forums to bring partners together to implement the TOHSS grant.   |                          |    |     | X  |
| 4. Strengthen state oral health coalition and 32 local oral health coalitions, to help unite the different counties and oral health stakeholders.  |                          |    |     | X  |

|  |  |  |   |   |
|--|--|--|---|---|
| 5. Fund local oral health programs to educate families and MCH-related programs.                   |  |  | X |   |
| 6. Maintain website with information on oral health promotion/education and access to dental care. |  |  | X |   |
| 7. Work with stakeholders to develop the state oral health plan.                                   |  |  |   | X |
| 8. Collect statewide dental caries experience data.  |  |  |   | X |
| 9.   |  |  |   |   |
| 10.  |  |  |   |   |

#### **b. Current Activities**

OMCH is working with the University of Washington School of Dentistry to develop curriculum for training general dentists to provide comprehensive dental services to Children with Special Health Care Needs with minor to moderate chronic conditions.

The Oral Health Program is working with partners to develop a state oral health plan.

CHILD Profile continues mailing health promotion letters that include information on oral health to parents of children aged birth-6 years.

The Oral Health Program is funding local health agencies to educate stakeholders and the public about the effective measures to prevent tooth decay.

The Oral Health Program is working with partners to tailor the Tooth Tutor messages to align with the Washington State Essential Academic Learning Requirements (EALRs). These materials will be available online for the upcoming school year.

The Oral Health Program is continuing to support the state oral health coalition and 32 local oral health coalitions, which unite the different counties and oral health stakeholders.

The Oral Health Program continues to maintain a website with information on oral health and access to dental care.

The Oral Health Program has been developing the state and county, school and child care samples and working with partners to identify funding for the Smile Survey 2010.

#### **c. Plan for the Coming Year**

OMCH will work with University of Washington School of Dentistry to conduct trainings at pilot sites using the curriculum developed in 2009. The trainings will be offered to dental and medical providers. This will enable them to provide comprehensive dental services to Children with Special Health Care Needs with minor to moderate chronic conditions. These services will be provided in private practice settings which will reduce the need for the children to be treated in hospitals.

The Oral Health Program will continue to support the state oral health coalition and 32 local oral health coalitions, which unite the different counties and oral health stakeholders.

CHILD Profile will continue mailing health promotion letters that include information on oral health to parents of children aged 0-6 years.

The OMCH Oral Health Program will work with partners to complete the state oral health plan and disseminate it statewide.

The Oral Health Program will also collect data on dental caries experience in third grade children as a part of the Smile Survey 2010.

**State Performance Measure 7:** *Strengthen statewide system capacity to promote health, safety, and school readiness of children birth to kindergarten entry.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| <b>Annual Objective and Performance Data</b> | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b>                                  |
|--|-------------|-------------|-------------|-------------|--|
| Annual Performance Objective                 |             |             | 54          | 82.8        | 97.2   |
| Annual Indicator                             |             | 25.2        | 48.6        | 86.4        | 100  |
| Numerator                                    |             |             |             |             |  |
| Denominator                                  |             |             |             |             |  |
| Data Source                                  |             |             |             |             | WA State Child and Adolescent Health Section |
| Is the Data Provisional or Final?            |             |             |             | Final       | Final  |
|  | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                                  |
| Annual Performance Objective                 | 100         | 100         | 100         | 100         | 100  |

**Notes - 2008**

This is a process measure (work being accomplished is groundbreaking & harder to quantify), w/ 28 benchmarks (statements describing annual work), weighted ~3.6% each with the goal of 100% attainment by 2010.

In 2008 all 28 benchmarks were attained, including the following new benchmarks:

- Maintain collaborations/partnerships with public and private sectors addressing health, safety and school readiness of children 0-5.
- Disseminate findings from Kids Matter implementation grant.
- Achieve full compliance of statewide users reporting in Healthy Child Care Washington (HCCW) data collection system.
- Develop and implement a plan to reduce barriers/promote strengths in HCCW network to support nurturing relationships and healthy environments in child care.

These data are provided by the Office of Maternal and Child Health, Child and Adolescent Health Section of the Washington State Department of Health, Division of Community and Family Health.

**Notes - 2007**

This is a process measure. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). There are 28 benchmarks, weighted ~3.6% each with the goal of 100% attainment by 2010.

The following new benchmarks have been attained:

- Provide technical assistance and training to Child Care Health Consultants regarding Kids Matter and implementation activities.
- Identify existing OMCH data that can inform Kids Matter indicators and outcomes.
- Identify system level indicators for components of Kids Matter.

- Communicate health and safety in school readiness efforts based on Kids Matter system level outcomes across OMCH.

- Link Kids Matter indicators and outcomes to OMCH 9 priorities.

- Provide technical assistance and training to users of web-based data collection system for Healthy Child Care Washington (HCCW).

- Identify key HCCW policy messages and dissemination strategies.

- Create and disseminate annual report for Healthy HCCW.

#### **Notes - 2006**

This is a process measure. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). There are 28 benchmarks, weighted ~3.6% each with the goal of 100% attainment by 2010.

The following new benchmarks have been achieved:

- Identify opportunities for funding and/or partnership initiatives related to health, safety and school readiness of children 0-5.

- Identify opportunities for funding and/or partnership initiatives to sustain the statewide system of Child Care Health Consultation.

- Monitor Kids Matter indicators and outcomes.

- Share information with Kids Matter planners and OMCH staff to inform efforts related to health, safety and school readiness.

- Review user feedback to determine if changes to Healthy Child Care Washington (HCCW) data collection system or training or technical assistance are needed.

- Make changes to HCCW data collection system as needs are identified.

- Disseminate key HCCW policy messages to related groups and initiatives.

- Identify barriers and strengths in HCCW network to promoting nurturing relationships and healthy environments in child care.

- Use information and data gathered from Kids Matter in Years 1-4 to inform 2010 OMCH Needs Assessment.

#### **a. Last Year's Accomplishments**

SPM07 supports OMCH's role in promoting health, safety, and school readiness. It also supports the Maternal Child Health Bureau's emphasis on systems development and integration through the federal Early Childhood Comprehensive Systems (ECCS) grant. The ECCS grant has five required components: Access to health and medical home; Social-emotional development and children's mental health; Early care and education; Parenting; and Family support. MCH Priorities 1) Adequate nutrition and physical activity, 3) Optimal Mental Health and Healthy Relationships, 4) Health disparities, 5) Safe and healthy communities, 6) Healthy physical growth and cognitive development, 8) Access to preventive and treatment services, and 9) Quality screening, identification intervention, and care coordination are also supported through SPM07.

ECCS and the Kids Matter partnership that developed out of ECCS, focused on increasing

systems capacity and integration of early childhood systems and services in Washington. Kids Matter continued to use and refine the outcome-based early childhood plan/framework called Kids Matter: Improving Outcomes for Children in Washington State. Three statewide system building efforts combined to create this plan: ECCS (OMCH/DOH)], the Foundation for Early Learning, and the Head Start-State Collaboration Office. Kids Matter's systems-building efforts were further integrated with Washington's Build Initiative efforts. The Build Initiative is supported through the National Build Initiative, an Early Childhood Funders Collaborative. Public and private partners across Washington State developed and support the use of this plan.

Kids Matter provided a framework and strategies to: 1) Improve early childhood outcomes; 2) Increase public will about early learning; and 3) Build and sustain public-private partnerships to facilitate changes in policies, programs and practices. Examples included: opportunities focused at building public-private partnerships related to Medical Home, Bright Futures, Healthy Child Care Washington (HCCW), and early childhood systems capacity.

The last annual Kids Matter Awareness and Utilization Survey was completed in February 2008. The survey report summarized the last three annual surveys showing increased use of the Kids Matter Framework, and continued interest in technical assistance to support its use.

The Kids Matter plan has been used as a resource for state and local early childhood initiatives, including Strengthening Families in Early Care and Education, Born Learning, Kids Matter Venture Grants in two regions, and replication projects for family, friend, and neighbor care providers. In fall 2007 a Kids Matter Guidebook was developed to assist local communities in strategic planning and prioritization using the Kids Matter Framework. State agencies and organizations have also used the Kids Matter Guidebook to assist in planning and prioritization.

Kids Matter messages included: keeping children and families as the focus; assuring that state agencies and organizations work together; facilitating cross-system collaboration between health and education; guiding state policies and actions to support local communities; and encouraging public-private collaborations like that between Department of Early Learning (DEL), Thrive by Five Washington and the Early Learning Advisory Council.

The Kids Matter framework and related efforts have coordinated with DOH's participation in the Washington State Mental Health Transformation (MHT) Grant. Implementation of Kids Matter was a MHT Grant implementation strategy submitted to the Governor's Office by DOH. Activities included identifying priorities for a more coordinated, statewide approach to prevention of mental health challenges in young children.

HCCW and ECCS staff in OMCH, and other early childhood stakeholders promoted HCCW as a system-level partnership to coordinate policies and practices related to health, safety, and optimal child development in child care, early learning, and after school settings.

CHILD Profile mailed health promotion letters that included information on school readiness to parents of children aged birth to six years. CHILD Profile also mailed the Getting School Ready booklet, created by Getting School Ready, a project of the Foundation for Early Learning.

**Table 4b, State Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Make formal presentations regarding Kids Matter to OMCH sections and external early childhood stakeholders.   |                          |    |     | X  |
| 2. Complete Awareness and Utilization Survey of broad early childhood stakeholder group regarding Early Childhood Comprehensive Systems (ECCS) grant and Kids Matter, the partnership and strategic plan/framework that developed from it. |                          |    |     | X  |

|   |  |   |  |   |
|---|--|---|--|---|
| 3. Use Kids Matter in various grant writing and contract opportunities across OMCH that incorporate the five required components of ECCS and align with the nine OMCH priorities. |  |   |  | X |
| 4. Increase coalition building efforts to expand public-private partnerships and implementation of the Kids Matter strategic plan.  |  |   |  | X |
| 5. Integrate strategic planning activities across OMCH using Kids Matter framework.   |  |   |  | X |
| 6. Evaluate Kids Matter.  |  |   |  | X |
| 7. Integrate Bright Futures Guidelines across components of Healthy Child Care Washington (HCCW) and Kids Matter.   |  |   |  | X |
| 8. Encourage the use of the Kids Matter framework at the local level through community mobilization work with partners.   |  |   |  | X |
| 9. Support statewide network of child care health consultants.  |  | X |  |   |
| 10.   |  |   |  |   |

#### **b. Current Activities**

As a member of the Strengthening Families Washington (SFWA) Steering Committee, Kids Matter is expanding partnerships and funding opportunities linking the Strengthening Families through Early Care and Education approach across state and local agencies. SFWA's Theory of Change is informing the development of a state work plan and evaluation plan with technical assistance from a contracted evaluation consultant.

Kids Matter is using the Kids Matter Guidebook to inform strategic planning activities across OMCH and assist local early learning community coalitions in systems development efforts. Funding options are being investigated to build capacity for technical assistance.

CHILD Profile mails health promotion letters including information on school readiness, and the Getting School Ready booklet to parents of children aged birth-6 years.

Child care health consultants, use Bright Futures and Kids Matter in their work with child care providers, as they work to improve school readiness through quality child care.

DOH has a grant from the Substance Abuse Mental Health Services Administration for Project LAUNCH, Linking Actions for Unmet Needs in Children's Health. It supports evidence-based-practices to children birth-8 and their families in one local community, Yakima. LAUNCH work aligns with ECCS and builds on MHT grant work. LAUNCH staff are working with the ECCS lead, DOH child and family mental health lead, and key stakeholders to develop a state-level strategic plan.

#### **c. Plan for the Coming Year**

Kids Matter will partner with DEL and the public-private partnership, Thrive by Five Washington, to create a new Early Learning Plan (ELP). The ELP is a statutory requirement of the state Early Learning Advisory Council (ELAC). The ELP will build on the Kids Matter Framework. Indicators and outcomes will be identified across ECCS domains: Health; Social-emotional development and children's mental health; Early care and education; and Parent and family support. The ELP will emphasize parent partnership, equity, and local participation. ECCS goals will also focus state and local efforts toward four strategic priority initiatives related to the required components of ECCS: Reach Out and Read Washington (ROR-WA)/Health; Project LAUNCH/Social-Emotional development and Children's Mental Health; Child Care Health Consultation/Early Care and Education; and SFWA/Parenting and Family Support.

Project LAUNCH staff, partners and stakeholders will refine the required LAUNCH strategic plan, goals and objectives building on the environmental and financial scan and at the same time

informing the work of the larger state ELP. A Year 3 continuation grant will be submitted to SAMHSA. Evaluation will include participation in national cross-site efforts as well as integration in ECCS and the ELP. Systems work will include meetings of the key partners, and focus on strengthening linkages and developing sustainability. We will pursue structural opportunities that would support integration and long term sustainability promoting young child wellness. The Project LAUNCH coordinator will continue to provide oversight for the LAUNCH grant, including state systems activities and the local community efforts to provide evidence-based interventions in five areas: Home visiting; Developmental screening and early intervention; Integrating primary care and behavioral health; Mental health consultation; and Parent support.

Kids Matter will continue to partner with Washington's Strengthening Families initiative (SFWA) to integrate the five protective factors: Parental resilience; Social connections; Knowledge of parenting and child development; Concrete support in times of need; and Social-emotional development of young children. SFWA and Kids Matter will explore structural options to align the SFWA and Kids Matter Steering Committee's. A new structure would strengthen and support systems level efforts and on the ground work while emphasizing parent partnerships and the protective factors.

DOH in partnership with DEL and other early childhood stakeholders will study options to update the child care health consultation role as part of a broader array of consultation services in early learning.

CHILD Profile plans to continue mailing health promotion letters that include information on school readiness to parents of children aged birth-6 years. CHILD Profile also plans to continue mailing the Getting School Ready booklet.

**State Performance Measure 8:** *Use an established framework for ensuring quality screening, identification, intervention, and care coordination for women, infants, children, adolescents, and their families.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008   |
|---------------------------------------|------|------|------|------|--|
| Annual Performance Objective          |      |      |      |      |  |
| Annual Indicator                      |      |      |      |      | 100  |
| Numerator                             |      |      |      |      |  |
| Denominator                           |      |      |      |      |  |
| Data Source                           |      |      |      |      | WA State Office of Maternal and Child Health |
| Is the Data Provisional or Final?     |      |      |      |      | Final  |
|                                       | 2009 | 2010 | 2011 | 2012 | 2013   |
| Annual Performance Objective          | 100  | 100  | 100  | 100  | 100  |

#### Notes - 2008

All quality improvement measures in the OMCH used the established framework.

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

#### Notes - 2007

No data available as this is a new State Performance Measure.

#### a. Last Year's Accomplishments

OMCH convened a cross office workgroup to develop a performance measure for the Quality Screening, Identification, Intervention, and Care Coordination priority. The workgroup reviewed quality improvement projects related to screening, identification, early intervention and care coordination that OMCH staff worked on. The workgroup worked to develop a single performance measure to indicate quality across all these efforts. They were not able to identify a single measure as the activities were so disparate. The workgroup felt that all of these activities should follow a similar approach to quality improvement. They modified the Kids Matter Framework to develop a single approach for all quality improvement projects in OMCH related to screening, identification, intervention, and care coordination. The new framework is attached.  
***An attachment is included in this section.***

**Table 4b, State Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Convene a cross office workgroup to develop a performance measure for the for the Quality Screening, Identification, Intervention, and Care Coordination priority. |                          |    |     | X  |
| 2. Review quality improvement projects related to screening, identification, early intervention and care coordination.  |                          |    |     | X  |
| 3. Develop a single approach for all quality improvement projects in OMCH related to screening, identification, intervention, and care coordination.                  |                          |    |     | X  |
| 4.  |                          |    |     |    |
| 5.  |                          |    |     |    |
| 6.  |                          |    |     |    |
| 7.  |                          |    |     |    |
| 8.  |                          |    |     |    |
| 9.  |                          |    |     |    |
| 10.   |                          |    |     |    |

#### **b. Current Activities**

This workgroup distributed the Quality Improvement framework to staff in OMCH, and identified the projects which are beginning to use this framework. These projects include: Early Hearing Diagnosis, Detection and Intervention projects, the Family Health History Pilot, the Perinatal Regional Network Rapid HIV Testing in Labor and Delivery, the Perinatal Advisory Committee Cesarean Section Subcommittee work, the American Indian Health Commission Maternal and Infant Health Subcommittee, the Tacoma Health Department First Steps Outreach to African Americans, the Medical Home Partnership project, the Epilepsy Grant, The Autism Grant, the Developmental Screening Brief, the Neurodevelopmental Center Granting Process, CHILd Profile Mailings, Child Care Health Consultation and Bright Futures.

The workgroup has begun to catalog project activities and has linked them to the steps of the framework. This catalog is intended as a reference for future projects, and a tool to determine whether a single performance measure or group of measures could describe all of the quality improvement work related to screening, early identification, intervention and care coordination.

#### **c. Plan for the Coming Year**

The workgroup will continue to promote the framework across OMCH. In addition, they will complete the catalog and develop quality improvement outcome measures for projects using the framework.

We hope to develop outcome measures that are broad enough to encompass most or all of the

quality improvement projects. If we are not able to develop broad outcome measures, we will develop several project-specific outcome measures.

**State Performance Measure 9:** *Develop an outcome measure for the Washington State maternal and child health priority of Optimal Mental Health and Healthy Relationships.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008   |
|---------------------------------------|------|------|------|------|--|
| Annual Performance Objective          |      |      |      |      |  |
| Annual Indicator                      |      |      |      |      | 39.9   |
| Numerator                             |      |      |      |      |  |
| Denominator                           |      |      |      |      |  |
| Data Source                           |      |      |      |      | Washington State Office of Maternal and Child Heal |
| Is the Data Provisional or Final?     |      |      |      |      | Final  |
|                                       | 2009 | 2010 | 2011 | 2012 | 2013   |
| Annual Performance Objective          | 60   | 100  | 100  | 100  | 100  |

**Notes - 2008**

This is a process measure created with the goal of developing an outcome measure. There are 8 benchmarks describing tasks, each variably weighted according to their importance. SPM09 is anticipated to be complete in 2010

Benchmarks with degree of completion:

-Complete literature review to identify best practices for achieving specific desirable outcomes. 100% complete

-Identify existing mental health/healthy relationship activities (initiatives) being done in OMCH and identify any new activities that would be appropriate to add. 100% complete

-Determine if OMCH wants to adopt a specific theoretical model for promoting behavior change and use the model to help identify desired outcomes of the identified activities. 50% complete

-Determine short, intermediate, and long term outcomes for each activity. 66% complete

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

**Notes - 2007**

No data are available. This is a new State Performance Measure.

**a. Last Year's Accomplishments**

OMCH worked on developing a new state performance measure for the Optimal Mental Health and Health Relationships priority.

OMCH was involved in many activities to promote optimal mental health and healthy relationships.

OMCH represented DOH on the Mental Health Transformation (MHT) Grant Workgroup. Child

and Adolescent Health (CAH) staff participated on the MHT Prevention Workgroup.

CAH supported the development of school-based health centers (SBHC), which provide primary care, reproductive health care and mental health care.

Social, emotional, and mental health was a focus area of the Early Childhood Comprehensive Systems (ECCS) grant.

Maternal and Child Health (MIH) First Steps staff encouraged First Steps providers to complete the perinatal depression web-training module and implement depression screening for pregnant and post-partum women.

Parents of children aged birth-6 years received mailings via CHILD Profile regarding parenting and child development. Parents of infants also receive information about postpartum depression in their mailings.

OMCH worked with the Department of Early Learning (DEL), Council for Children and Families (CCF), and other stakeholders to promote mental health consultation to child care and early learning providers. Child care health consultants (CCHCs) provide training and technical assistance regarding social emotional development, to child care providers serving infants and toddler. This is part of the Healthy Child Care Washington (HCCW) initiative administered by CAH and funded by DEL.

**Table 4b, State Performance Measures Summary Sheet**

| Activities   | Pyramid Level of Service |    |     |    |
|--|--------------------------|----|-----|----|
|  | DHC                      | ES | PBS | IB |
| 1. Participate on the Mental Health Transformation Prevention Work Group.  |                          |    |     | X  |
| 2. Support the development of School Based Health Centers.   |                          |    |     | X  |
| 3. Implement the social, emotional and mental health component of the Early Childhood Comprehensive Systems (ECCS) Grant.  |                          |    |     | X  |
| 4. Encourage First Steps providers to complete the Perinatal depression web-training module collaboratively developed by First Steps and University of Washington. |                          |    |     | X  |
| 5. Send parents information on parenting and child development via CHILD Profile health promotion mailings.  |                          |    | X   |    |
| 6. Promote social emotional and mental health consultation to child care, early learning providers.  |                          |    | X   |    |
| 7.   |                          |    |     |    |
| 8.   |                          |    |     |    |
| 9.   |                          |    |     |    |
| 10.  |                          |    |     |    |

**b. Current Activities**

An OMCH workgroup has been meeting to develop an outcome measure related to optimal mental health and healthy relationships. We will not be able to complete it this year. It will be complete by April 2010.

OMCH informs and coordinates DOH's participation on the MHT Grant Workgroup. CAH staff participates on the MHT Prevention Workgroup.

CAH supports the development and implementation of SBHCs, which provide primary care, reproductive health care and mental health care.

CAH implements the ECCS grant, through which the Kids Matter partnership and strategic plan/framework were developed. CAH works to infuse social, emotional and mental health promotion across all focus areas of ECCS: Medical Home, Early Care and Education, Parenting Education, and Family Support.

DOH received a federal Project LAUNCH grant to promote young child wellness. This builds on and coordinates with Kids Matter implementation. LAUNCH is working to increase coordination across public agencies and private organizations at the state level and in one local community as specified by the grant.

CAH links Kids Matter and the development of SBHCs with LAUNCH, MHT, and other mental health promotion activities.

CHILD Profile mails information regarding parenting and child development to parents of children aged birth-6 years.

CCHCs continue to provide training and technical assistance regarding social emotional development, behavior, and nurturing relationships to child care providers serving infants and toddlers.

### **c. Plan for the Coming Year**

The OMCH workgroup will continue to meet to develop an outcome measure related to optimal mental health and healthy relationships. We plan to complete this work by April 2010.

OMCH will continue to inform and coordinate DOH's participation on the MHT grant workgroup. CAH staff will continue to participate on the MHT Prevention Workgroup (PAG). DOH, through the MHT grant workgroup and PAG, will inform and influence planning for ongoing activities when the MHT grant ends in September 2010.

CAH will support the development and implementation of SBHCs, which provide primary care, reproductive health care and mental health care.

CAH will continue to implement Kids Matter and work to infuse social, emotional and mental health promotion across all focus areas of Kids Matter: Medical Home, Early Care and Education, Parenting Education, and Family Support.

CAH will implement Project LAUNCH to promote young child wellness, building on and coordinating with Kids Matter. We will increase coordination across public agencies and private organizations at the state level and in one local community. DOH will continue to contract with one local community to implement evidence-based-practices to strengthen family and caregiver skills in promoting positive social emotional development.

CAH will link Kids Matter and the development of SBHCs with Project LAUNCH, MHT, and other mental health promotion activities.

CHILD Profile will mail information regarding parenting and child development to parents of children aged birth--6 years.

CCHCs will continue to provide training and technical assistance regarding social emotional development, behavior, and nurturing relationships to child care providers serving infants and toddlers.

First Steps will include mental health issues, including maternal mood disorders, in the restructuring of the Maternity Support Services program resulting in all pregnant Medicaid women participating in First Steps being screen for these conditions.

**State Performance Measure 10:** *Identify health disparities, develop and implement interventions to address disparities, and evaluate the effectiveness of interventions in achieving health equity.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004        | 2005        | 2006        | 2007        | 2008   |
|---------------------------------------|-------------|-------------|-------------|-------------|--|
| Annual Performance Objective          |             |             |             |             |  |
| Annual Indicator                      |             |             |             |             | 2.5  |
| Numerator                             |             |             |             |             |  |
| Denominator                           |             |             |             |             |  |
| Data Source                           |             |             |             |             | WA State Office of Maternal and Child Health |
| Is the Data Provisional or Final?     |             |             |             |             | Final  |
|                                       | <b>2009</b> | <b>2010</b> | <b>2011</b> | <b>2012</b> | <b>2013</b>                                  |
| Annual Performance Objective          | 3           | 3           | 3           | 3           | 3  |

**Notes - 2008**

This measure is the average score given by the various participating sections in the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Genetics – 3  
 CSHCN – 3  
 CAH – 2  
 IPCP – 3  
 Oral Health – 2  
 MIH – 2

OMCH average score – 2.5

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

**Notes - 2007**

No data are available. This is a new State Performance Measure.

**a. Last Year's Accomplishments**

The OMCH Health Disparities workgroup completed the Health Equity issue brief in spring 2008. Between May and August 2008, they co-hosted a series of interactive presentations featuring local speakers and video from the PBS series Unnatural Causes. Evaluations of the events showed that staff in attendance felt they were more knowledgeable about health disparities after attending the trainings.

Maternal and Infant Health (MIH) staff networked and built partnerships with key community informants and organizations representing groups experiencing health disparities for to inform strategies in OMCH aimed at addressing disparities.

MIH contracted with Tacoma-Pierce County Health Department to conduct culturally sensitive outreach to African American, Medicaid eligible pregnant women in Pierce County.

The Immunization Program CHILD Profile (IPCP) collaborated on educational outreach activities to Asian Pacific Islander (API) populations about hepatitis B. Community projects and screenings were done based on 2007-08 key objectives to increase hepatitis B screening and immunization in the API population.

The Child and Adolescent Health (CAH) section funded two school-based health centers (SBHC) and 11 SBHC planning grants targeting rural areas, schools with low test scores, and socioeconomically and racially/ethnically diverse populations.

Early Childhood Comprehensive Systems partners (Kids Matter) used the Race Matters Toolkit ([www.aecf.org](http://www.aecf.org)) to review policies and practices regarding disparities for children, families, and communities.

The Children with Special Health Care Needs (CSHCN) Epilepsy Project conducted a Needs Assessment to collect information to better serve the needs of children and youth with epilepsy and seizure disorders, especially in the Hispanic population in medically underserved and rural areas of central Washington. Meetings and trainings were conducted for Care Coordinators, School Nurses, Health Consultants, Promotoras (community members who serve as liaisons between their community and health, human and social service organizations), and families, to provide information and materials on epilepsy and seizure disorders.

CSHCN completed a needs assessment of autism issues through activities of the Autism Task Force (ATF) and in preparation for an MCHB autism grant opportunity. Fathers Network, with support of epilepsy grant monies, has completed the DVD Tres Familias. It presents the stories of three Hispanic families with children with special needs. One of these families has a child with epilepsy. It is a tool to help providers understand parents' views. The DVD is in Spanish with English subtitles.

A process measure was selected to measure how the sections within the OMCH work to create health equity for women, infants, children, adolescents, and families. By selecting a measure that holds sections accountable for the process used to address health disparities, we hope to ensure continued efforts to achieve health equity. See the data notes for information on how this process measure will be reported in future block grant applications. The measure aligns with Washington State's MCH priority, Health Equity.

**Table 4b, State Performance Measures Summary Sheet**

| Activities  | Pyramid Level of Service |    |     |    |
|---|--------------------------|----|-----|----|
|   | DHC                      | ES | PBS | IB |
| 1. Assess disparities and work with target communities to improve maternal and infant outcomes.   |                          |    | X   |    |
| 2. Collaborate on educational and outreach activities to the Asian Pacific Islander, Native American, and African American communities, including community projects and screenings.        |                          | X  |     |    |
| 3. Coordinate with other organizations and agencies to ensure that adolescents have access to age appropriate and culturally appropriate health services.                                   |                          |    |     | X  |
| 4. Use the Race Matters Toolkit to view the Early Childhood Comprehensive Systems/Kids Matter work through a racial equity lens and improve results across early childhood systems.         |                          |    |     | X  |
| 5. Improve access to care for children and youth with epilepsy and seizure disorders, especially in the Hispanic population in medically underserved and rural areas of central Washington. |                          |    |     | X  |
| 6. Engage and empower new stakeholders; coordinate training to providers and families, and impact existing benefit systems for  |                          |    |     | X  |

|   |  |   |   |  |
|---|--|---|---|--|
| children with special healthcare needs, particularly those with Autism Spectrum Disorder and other developmental disabilities.                |  |   |   |  |
| 7. Work with targeted high-need community to promote wellness (physical, social, emotional and behavioral) of young children and families.    |  | X |   |  |
| 8. Implement school based dental sealant programs targeting schools with 305 or more of children eligible for free and reduced lunch program. |  |   | X |  |
| 9.  |  |   |   |  |
| 10.   |  |   |   |  |

#### **b. Current Activities**

OMCH is conducting assessments of health equity work for each section.

MIH contracts with local agencies to conduct faith based outreach to African American women, and to explore ways to increase tribal participation in First Steps and best practices for working with American Indian women.

IPCP conducts outreach to Asian Pacific Islanders about hepatitis B. IPCP works with the American Indian Health Commission to improve immunization coverage for American Indians.

Kids Matter is working to develop action oriented steps to reduce disparities.

CSHCN Epilepsy Project promotes medical homes, especially in Hispanic populations in underserved areas of Central Washington. CSHCN program distributes the Tres Familias DVD to providers.

CSHCN conducts training for families and providers about impacting systems change for families of children with Autism Spectrum Disorder, they are also active in Combating Autism Advisory Council meetings.

CAH administers Project LAUNCH, providing services to families in a community with high poverty and a higher percentage of Hispanic and Native American residents than the Washington average.

The Oral Health Program funds 13 local oral health programs to implement school based dental sealant programs. These programs are specifically targeted to schools that have 30% or more children eligible for free and reduced lunch program.

#### **c. Plan for the Coming Year**

MIH will work with leaders in African American communities to plan a summit in Pierce and King Counties to develop a strategy for improving maternal and infant indicators, such as access to early prenatal care and infant mortality.

IPCP is collaborating with the American Indian Health Commission to develop strategies to improve immunization coverage rates among American Indian/Native American populations. These strategies will include greater collaboration between CHILD Profile staff and Indian Health Service electronic medical records staff to increase the number of childhood records successfully downloaded into the CHILD Profile immunization registry. Another goal will be a baseline immunization coverage rate assessment of tribal and Indian Health Service clinics.

The Hepatitis B Coalition of Washington will continue reaching, engaging and educating families and household member of individuals from immigrant communities who have hepatitis B. The Coalition also plans to expand their work to immigrants, refugees and other high risk populations.

The Genetic Services Section, Early Hearing-loss Detection, Diagnosis and Intervention program data revealed that infants lost to follow-up after failing their hearing screen were typically in rural areas and born to young women (less than 25 years old) and/or women with limited education. With this in mind program staff are initiating multiple strategies to better inform this group about the importance of hearing screening and early identification of hearing loss. These will include issuing public service announcements focused in rural areas, putting educational information in school health clinics; hospital based birthing classes, and obstetrical offices.

CSHCN Epilepsy Project will continue to work to improve community-based system of services for children and youth with epilepsy; improve services in medically underserved and rural areas of Central Washington; increase access to direct services where there is a significant Hispanic population; develop co-management strategies to improve communication between parents of children and youth with epilepsy, primary care providers, specialists, and other health care providers.

CSHCN Autism Project will continue to focus on the grant goals of engaging and empowering new stakeholders; coordinating training for providers and families; and impacting existing benefit systems for children with special health care needs particularly those with Autism Spectrum Disorder and other developmental disabilities. They will also continue to work with partners to increase access to diagnostic services in several Eastern Washington communities; increase training opportunities for Parent to Parent Coordinators; and increase families' awareness of health care systems in Washington.

## E. Health Status Indicators

### Introduction

Raw data are used by DOH staff to produce reports and other publications, respond to legislative requests, and prepare presentations. Published documents are used by numerous stakeholders and the general public.

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data   | 2004  | 2005  | 2006  | 2007  | 2008 |
|---|-------|-------|-------|-------|------|
| Annual Indicator  | 6.2   | 6.1   | 6.5   | 6.3   |      |
| Numerator   | 5063  | 5040  | 5659  | 5625  |      |
| Denominator   | 81715 | 82625 | 86845 | 88803 |      |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |       |       |       |       |      |
| Is the Data Provisional or Final?   |       |       |       | Final |      |

### Notes - 2008

No data available for 2008.

### Notes - 2007

The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Notes - 2006**

Data trends have shown an increase since 1999, in part due to the increase in multiple births. However, the singleton LBW rate has also increased steadily. This rate is determined by (the number of live births weighing less than 2500 grams divided by the total number of resident live births)\*1000. The source for these data are 2005 Natality Tables D1 and D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Narrative:**

The rate of low birth weight for overall births (multiple or singleton) has shown a gradual increase since 1996. Washington State continues to have one of the lowest rates for low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.

For more complete information on activities and strategies targeting low birth weight see HSCI05A and NPM17.

**Health Status Indicators 01B:** *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 4.8         | 4.7         | 5.0         | 4.9         |             |
| Numerator   | 3805        | 3765        | 4213        | 4197        |             |
| Denominator   | 79268       | 80109       | 84081       | 86098       |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

No data are available for 2008.

**Notes - 2007**

Data trends have shown relatively flat rates since 1999. The source for these data are 2007 Natality Tables D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Notes - 2006**

Data trends have shown relatively flat rates since 1999. This rate is determined by (the number of singleton live births weighing less than 2500 grams divided by the total number of resident singleton live births)\*1000. The source for these data are 2006 Natality Tables D1 and D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Narrative:**

The rate of low birth weight for singleton births has shown a gradual increase since 1996. Washington State continues to have one of the lowest rates for singleton low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.

For more complete information on activities and strategies targeting low birth weight see HSCI05A and NPM17.

**Health Status Indicators 02A:** *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 1.1         | 0.9         | 1.0         | 1.1         |             |
| Numerator   | 870         | 750         | 872         | 965         |             |
| Denominator   | 81715       | 82625       | 86845       | 88803       |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional |

**Notes - 2008**

No data are available for 2008.

**Notes - 2007**

The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Notes - 2006**

While it is not visible in the rates presented, the total VLBW increased an average 1.3% per year since 1990. This rate is determined by (the number of live births weighing less than 1500 grams divided by the total number of resident live births)\*1000. The source for these data are 2005 Natality Tables D1 and D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Narrative:**

Very low birth weight deliveries (singleton or multiple) have remained stable since 1996. Washington State continues to have one of the lowest rates for very low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.

For more information on low birth weight see HSCI05A and NPM17.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 0.8         | 0.7         | 0.8         | 0.8         |             |
| Numerator   | 657         | 568         | 652         | 721         |             |
| Denominator   | 79268       | 80109       | 84081       | 86098       |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Provisional |

**Notes - 2008**

No data available for 2008.

**Notes - 2007**

Singleton VLBW rates show no clear trend and has been very stable since the mid-1990s. The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Notes - 2006**

Singleton VLBW rates show no clear trend. This rate is determined by (the number of singleton live births weighing less than 1500 grams divided by the total number of resident singleton live births)\*1000. The source for these data are 2005 Natality Tables D1 and D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

**Narrative:**

Very low birth weight deliveries of singletons has remained stable since 1996. Washington State continues to have one of the lowest rates for very low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions will impact the percent of women who may be served by these programs in 2010.

For more complete information on activities and strategies targeting low birth weight see HSCI05A and NPM17.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>   | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator   | 8.6         | 7.3         | 6.7         | 5.6         |             |
| Numerator  | 108         | 92          | 85          | 72          |             |
| Denominator  | 1257310     | 1259643     | 1270785     | 1281739     |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the |             |             |             |             |             |

|   |  |  |  |       |  |
|---|--|--|--|-------|--|
| last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |  |  |  |       |  |
| Is the Data Provisional or Final?   |  |  |  | Final |  |

**Notes - 2008**

Data are not available for 2008.

**Notes - 2007**

The rate is determined by (the number of unintentional injury death among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2006**

The rate is determined by (the number of unintentional injury death among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

There has been no significant change since 1998 in the rate of death for children 14 years and younger.

For more complete information on OMCH activities to reduce fatal unintended injuries see NPM10.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 1.8         | 3.1         | 1.7         | 2.0         |             |
| Numerator   | 23          | 39          | 21          | 26          |             |
| Denominator   | 1257310     | 1259643     | 1270785     | 1281739     |             |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

Data are not available for 2008.

**Notes - 2007**

The rate is determined by calculating the number of unintentional injury deaths among children 14 years and younger due to motor vehicle crashes divided by the number of children age 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2006**

The rate is determined by (the number of unintentional injury death among children 14 years and younger due to motor vehicle crashes divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

There has been no significant change since 1998 in the rate of death due to motor vehicle crashes for children 14 years and younger.

For more complete information on OMCH activities to reduce fatal unintended injuries see NPM10.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 19.6        | 17.8        | 21.7        | 17.9        |             |
| Numerator   | 173         | 160         | 200         | 168         |             |
| Denominator   | 882550      | 898864      | 921059      | 938320      |             |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       |             |

**Notes - 2008**

Data not available for 2008.

**Notes - 2007**

The rate is determined by the number of unintentional injury deaths among children ages 15 to 24 years divided by the number of children age 15 to 24 years. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2006**

The rate is determined by (the number of unintentional injury death among children ages 15 to 24 years divided by children ages 15 to 24 years). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

There has been a significant downward trend since 1998 in the rate of death due to motor vehicle crashes for youth 15 to 24 years of age.

For more complete information on OMCH activities to reduce fatal unintended injuries see NPM10.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data   | 2004    | 2005    | 2006    | 2007    | 2008 |
|---|---------|---------|---------|---------|------|
| Annual Indicator  | 157.9   | 180.2   | 162.9   | 157.1   |      |
| Numerator   | 1985    | 2271    | 2070    | 2014    |      |
| Denominator   | 1257287 | 1260009 | 1270785 | 1281739 |      |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |         |         |         |         |      |
| Is the Data Provisional or Final?   |         |         |         | Final   |      |

**Notes - 2008**

Data are not available for 2008.

**Notes - 2007**

The rate is determined by (the number of nonfatal injuries among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

From 1999 - 2003, the non-fatal hospitalization rate for children and youth ages 0-14 declined significantly. However, in 2004 and 2005, the rates were higher than in 2002 and 2003. In 2007 the rates showed a decline for the second year in a row, below the 2004 rate and approximating the 2003 rate.

**Notes - 2006**

The rate is determined by (the number of nonfatal injuries among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

From 1999 - 2003, the non-fatal hospitalization rate for children and youth ages 0-14 declined significantly. However, in 2004 and 2005, the rates were higher than in 2002 and 2003. In 2006 the rates showed a decline.

**Narrative:**

There has been a significant downward trend since 1998 in the rate of nonfatal unintentional injuries for children 14 years and younger.

For more complete information on OMCH activities to reduce unintended injuries see NPM10.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---------------------------------------|------|------|------|------|------|
| Annual Indicator                      | 19.2 | 19.4 | 17.2 | 13.9 |      |

|   |         |         |         |         |  |
|---|---------|---------|---------|---------|--|
| Numerator   | 241     | 244     | 218     | 178     |  |
| Denominator   | 1257310 | 1259643 | 1270785 | 1281739 |  |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |         |         |         |         |  |
| Is the Data Provisional or Final?   |         |         |         | Final   |  |

#### Notes - 2008

Data are not available for 2008.

#### Notes - 2007

The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children 14 years and younger divided by the population of children ages 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

#### Notes - 2006

The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children 14 years and younger divided by children ages 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

#### Narrative:

There has been no significant change since 1998 in the rate of nonfatal injuries due to motor vehicle crashes for children 14 years and younger.

For more complete information on OMCH activities to reduce unintended injuries see NPM10.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data   | 2004   | 2005   | 2006   | 2007   | 2008 |
|---|--------|--------|--------|--------|------|
| Annual Indicator  | 108.2  | 113.5  | 106.0  | 95.3   |      |
| Numerator   | 955    | 1020   | 976    | 894    |      |
| Denominator   | 882550 | 898864 | 921059 | 938320 |      |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |        |        |        |        |      |
| Is the Data Provisional or Final?   |        |        |        | Final  |      |

#### Notes - 2008

No data are available for 2008.

#### Notes - 2007

The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children age 15 through 24 divided by the population of children age 15 through 24. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

2007 data show a continuing downward trend after a spike in the rate which culminated in 2005.

**Notes - 2006**

The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children ages 15 through 24 divided by children ages 15 through 24. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

There has been a significant downward trend since 1998 in the rate of injuries due to motor vehicle crashes for youth 15 to 24 years of age.

For more complete information on OMCH activities to reduce unintended injuries see NPM10.

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 22.6        | 22.7        | 21.1        | 21.3        | 23.3        |
| Numerator   | 4873        | 4990        | 4717        | 4859        | 5353        |
| Denominator   | 216028      | 219516      | 223862      | 227994      | 229650      |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final       |

**Notes - 2008**

The rate is determined by the number of women age 15 through 19 with a reported case of Chlamydia divided by the population of women age 15 through 19. The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2007**

The rate is determined by (the number of women ages 15 through 19 with a reported case of Chlamydia divided by women aged 15 through 19). The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2006**

The rate is determined by (the number of women ages 15 through 19 with a reported case of Chlamydia divided by women aged 15 through 19). The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

The incidence rate of Chlamydia for 15 to 19 year old females was stable from 2004 through 2007, but showed an increase in 2008. Some of this increase is due to more aggressive case reporting investigations and to better laboratory surveillance, but it may also reflect a very slight increase in actual morbidity.

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| <b>Annual Objective and Performance Data</b>  | <b>2004</b> | <b>2005</b> | <b>2006</b> | <b>2007</b> | <b>2008</b> |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Indicator  | 6.9         | 7.3         | 7.1         | 7.7         | 8.4         |
| Numerator   | 7521        | 7960        | 7857        | 8545        | 9375        |
| Denominator   | 1085707     | 1089135     | 1102129     | 1113192     | 1120549     |
| Check this box if you cannot report the numerator because<br>1. There are fewer than 5 events over the last year, and<br>2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. |             |             |             |             |             |
| Is the Data Provisional or Final?   |             |             |             | Final       | Final       |

**Notes - 2008**

The rate is determined by the number of women age 20 through 44 years with a reported case of Chlamydia divided by the population of women age 20 through 44 years. The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2007**

The rate is determined by (the number of women ages 20 through 44 years with a reported case of Chlamydia divided by women aged 20 through 44 years). The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Notes - 2006**

The rate is determined by (the number of women ages 20 through 44 years with a reported case of Chlamydia divided by women aged 20 through 44 years). The numerator is gathered from the Washington State Department of Infectious Disease and Reproductive Health. The denominator is gathered from the Office of Financial Management Population Forecast.

**Narrative:**

The incidence rate of Chlamydia for 20 to 44 year old females was stable from 2004 through 2007, but showed an increase in 2008. Some of this increase is due to more aggressive case reporting investigations and to better laboratory surveillance, but it may also reflect a very slight increase in actual morbidity.

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| <b>CATEGORY</b><br>TOTAL<br>POPULATION<br>BY RACE | <b>Total<br/>All<br/>Races</b> | <b>White</b> | <b>Black or<br/>African<br/>American</b> | <b>American<br/>Indian or<br/>Native<br/>Alaskan</b> | <b>Asian</b> | <b>Native<br/>Hawaiian<br/>or Other<br/>Pacific<br/>Islander</b> | <b>More<br/>than one<br/>race<br/>reported</b> | <b>Other<br/>and<br/>Unknown</b> |
|---|--------------------------------|--------------|--|--|--------------|--|--|----------------------------------|
| Infants 0 to 1                                    | 82996                          | 66181        | 3576                                     | 1691   | 4408         | 487  | 6653   | 0                                |
| Children 1 through 4                              | 337388                         | 270379       | 14763                                    | 7072   | 19009        | 2036   | 24129  | 0                                |
| Children 5 through 9                              | 424161                         | 345529       | 18562                                    | 9252   | 22837        | 2604   | 25377  | 0                                |
| Children 10 through 14                            | 437195                         | 359850       | 18599                                    | 9996   | 23892        | 2596   | 22262  | 0                                |
| Children 15 through 19                            | 468238                         | 385043       | 18852                                    | 10129  | 30067        | 3080   | 21067  | 0                                |
| Children 20 through 24                            | 470084                         | 385930       | 20182                                    | 9338   | 34210        | 3367   | 17057  | 0                                |
| Children 0 through 24                             | 2220062                        | 1812912      | 94534                                    | 47478  | 134423       | 14170  | 116545   | 0                                |

**Notes - 2010**

**Narrative:**

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| <b>CATEGORY</b><br>TOTAL POPULATION BY<br>HISPANIC ETHNICITY | <b>Total NOT Hispanic<br/>or Latino</b> | <b>Total Hispanic<br/>or Latino</b> | <b>Ethnicity Not<br/>Reported</b> |
|--|---|-------------------------------------|-----------------------------------|
| Infants 0 to 1   | 67637                                   | 15360                               | 0                                 |
| Children 1 through 4   | 281694                                  | 55693                               | 0                                 |
| Children 5 through 9   | 360878                                  | 63283                               | 0                                 |
| Children 10 through 14                                       | 387926                                  | 49268                               | 0                                 |
| Children 15 through 19                                       | 415750                                  | 52487                               | 0                                 |
| Children 20 through 24                                       | 410817                                  | 59266                               | 0                                 |
| Children 0 through 24  | 1924702                                 | 295357                              | 0                                 |

**Notes - 2010**

**Narrative:**

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 07A:** *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| <b>CATEGORY</b><br>Total live | <b>Total<br/>All</b> | <b>White</b> | <b>Black or<br/>African</b> | <b>American<br/>Indian or</b> | <b>Asian</b> | <b>Native<br/>Hawaiian</b> | <b>More<br/>than one</b> | <b>Other and<br/>Unknown</b> |
|-------------------------------|----------------------|--------------|-----------------------------|-------------------------------|--------------|----------------------------|--------------------------|------------------------------|
|-------------------------------|----------------------|--------------|-----------------------------|-------------------------------|--------------|----------------------------|--------------------------|------------------------------|

| births              | Races |       | American | Native Alaskan |      | or Other Pacific Islander | race reported |   |
|---------------------|-------|-------|----------|----------------|------|---------------------------|---------------|---|
| Women < 15          | 79    | 65    | 5        | 3              | 2    | 1                         | 3             | 0 |
| Women 15 through 17 | 2160  | 1747  | 109      | 123            | 34   | 15                        | 132           | 0 |
| Women 18 through 19 | 5075  | 4092  | 262      | 222            | 116  | 63                        | 320           | 0 |
| Women 20 through 34 | 66480 | 54068 | 2784     | 1266           | 5353 | 751                       | 2258          | 0 |
| Women 35 or older   | 13754 | 10958 | 492      | 131            | 1799 | 97                        | 277           | 0 |
| Women of all ages   | 87548 | 70930 | 3652     | 1745           | 7304 | 927                       | 2990          | 0 |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| <b>CATEGORY</b>     | <b>Total NOT Hispanic or Latino</b> | <b>Total Hispanic or Latino</b> | <b>Ethnicity Not Reported</b> |
|---------------------|-------------------------------------|---------------------------------|-------------------------------|
| Total live births   |                                     |                                 |                               |
| Women < 15          | 37                                  | 52                              | 0                             |
| Women 15 through 17 | 1282                                | 935                             | 0                             |
| Women 18 through 19 | 3692                                | 1518                            | 0                             |
| Women 20 through 34 | 54865                               | 12612                           | 0                             |
| Women 35 or older   | 12169                               | 1718                            | 0                             |
| Women of all ages   | 72045                               | 16835                           | 0                             |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| <b>CATEGORY</b> | <b>Total All Races</b> | <b>White</b> | <b>Black or African American</b> | <b>American Indian or Native Alaskan</b> | <b>Asian</b> | <b>Native Hawaiian or Other Pacific Islander</b> | <b>More than one race reported</b> | <b>Other and Unknown</b> |
|-----------------|------------------------|--------------|----------------------------------|--|--------------|--|------------------------------------|--------------------------|
| Total deaths    |                        |              |                                  |  |              |  |                                    |                          |
| Infants 0 to 1  | 423                    | 295          | 40                               | 25                                       | 21           | 10   | 32                                 | 0                        |
| Children 1      | 71                     | 56           | 1                                | 3  | 7            | 1  | 3                                  | 0                        |

|                        |      |     |    |    |    |    |    |   |
|------------------------|------|-----|----|----|----|----|----|---|
| through 4              |      |     |    |    |    |    |    |   |
| Children 5 through 9   | 46   | 41  | 2  | 2  | 1  | 0  | 0  | 0 |
| Children 10 through 14 | 54   | 47  | 2  | 0  | 1  | 0  | 4  | 0 |
| Children 15 through 19 | 221  | 179 | 12 | 14 | 8  | 1  | 7  | 0 |
| Children 20 through 24 | 330  | 273 | 19 | 12 | 16 | 4  | 6  | 0 |
| Children 0 through 24  | 1145 | 891 | 76 | 56 | 54 | 16 | 52 | 0 |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| <b>CATEGORY</b>        | <b>Total NOT Hispanic or Latino</b> | <b>Total Hispanic or Latino</b> | <b>Ethnicity Not Reported</b> |
|------------------------|-------------------------------------|---------------------------------|-------------------------------|
| Total deaths           |                                     |                                 |                               |
| Infants 0 to 1         | 335                                 | 92                              | 0                             |
| Children 1 through 4   | 56                                  | 17                              | 0                             |
| Children 5 through 9   | 37                                  | 9                               | 0                             |
| Children 10 through 14 | 49                                  | 5                               | 0                             |
| Children 15 through 19 | 201                                 | 20                              | 0                             |
| Children 20 through 24 | 293                                 | 40                              | 0                             |
| Children 0 through 24  | 971                                 | 183                             | 0                             |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| <b>CATEGORY</b>           | <b>Total All Races</b> | <b>White</b> | <b>Black or African American</b> | <b>American Indian or Native Alaskan</b> | <b>Asian</b> | <b>Native Hawaiian or Other Pacific Islander</b> | <b>More than one race reported</b> | <b>Other and Unknown</b> | <b>Specific Reporting Year</b> |
|---------------------------|------------------------|--------------|----------------------------------|--|--------------|--|------------------------------------|--------------------------|--------------------------------|
| Misc Data BY RACE         |                        |              |                                  |  |              |  |                                    |                          |                                |
| All children 0 through 19 | 1767367                | 1416685      | 79392                            | 38696                                    | 125416       | 0  | 107178                             | 0                        | 2008                           |
| Percent in household      | 24.9                   | 23.1         | 41.8                             | 61.8                                     | 20.3         | 17.5   | 32.9                               | 0.0                      | 2008                           |

|  |        |        |        |        |       |      |        |        |      |
|--|--------|--------|--------|--------|-------|------|--------|--------|------|
| headed by single parent                                  |        |        |        |        |       |      |        |        |      |
| Percent in TANF (Grant) families                         | 8.7    | 4.9    | 19.4   | 10.7   | 3.9   | 0.0  | 0.0    | 0.0    | 2005 |
| Number enrolled in Medicaid                              | 689229 | 338965 | 37239  | 14779  | 28096 | 0    | 138278 | 131872 | 2007 |
| Number enrolled in SCHIP                                 | 21359  | 11647  | 464    | 476    | 1300  | 0    | 3213   | 4259   | 2007 |
| Number living in foster home care                        | 11314  | 5726   | 742    | 868    | 106   | 0    | 3709   | 163    | 2007 |
| Number enrolled in food stamp program                    | 352284 | 173580 | 26548  | 8917   | 11980 | 0    | 81134  | 50125  | 2007 |
| Number enrolled in WIC                                   | 250766 | 178351 | 16018  | 6361   | 8964  | 3838 | 37234  | 0      | 2008 |
| Rate (per 100,000) of juvenile crime arrests             | 2223.0 | 2541.0 | 5065.0 | 3714.0 | 811.0 | 0.0  | 0.0    | 0.0    | 2006 |
| Percentage of high school drop-outs (grade 9 through 12) | 5.1    | 4.8    | 10.3   | 11.2   | 4.3   | 0.0  | 0.0    | 0.0    | 2006 |

## Notes - 2010

### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*  
(Demographics)

### HSI #09B - Demographics (Miscellaneous Data)

| <b>CATEGORY</b>                              | <b>Total NOT Hispanic or Latino</b> | <b>Total Hispanic or Latino</b> | <b>Ethnicity Not Reported</b> | <b>Specific Reporting Year</b> |
|--|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|
| Miscellaneous Data BY HISPANIC ETHNICITY     |                                     |                                 |                               |                                |
| All children 0 through 19                    | 1495474                             | 271893                          | 0                             | 2008                           |
| Percent in household headed by single parent | 24.5                                | 27.0                            | 0.0                           | 2008                           |
| Percent in TANF (Grant) families             | 7.1                                 | 14.9                            | 0.0                           | 2007                           |
| Number enrolled in Medicaid                  | 454681                              | 165955                          | 68592                         | 2007                           |
| Number enrolled in SCHIP                     | 12812                               | 4865                            | 3682                          | 2007                           |
| Number living in foster home care            | 9385                                | 1906                            | 23                            | 2007                           |
| Number enrolled in food stamp program        | 243281                              | 90599                           | 18404                         | 2007                           |
| Number enrolled in WIC                       | 153190                              | 97576                           | 0                             | 2005                           |
| Rate (per 100,000) of juvenile crime arrests | 0.0                                 | 1393.0                          | 0.0                           | 2006                           |

|  |     |     |     |      |
|--|-----|-----|-----|------|
| Percentage of high school drop-outs (grade 9 through 12) | 0.0 | 8.3 | 0.0 | 2006 |
|--|-----|-----|-----|------|

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

#### Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

##### HSI #10 - Demographics (Geographic Living Area)

| Geographic Living Area                   | Total    |
|--|----------|
| Living in metropolitan areas             | 1167447  |
| Living in urban areas                    | 14016585 |
| Living in rural areas                    | 171691   |
| Living in frontier areas                 | 124554   |
| <b>Total</b> - all children 0 through 19 | 14312830 |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

For a map of Washington State's general population density, see attachment to section IIIA, State Overview.

#### Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

##### HSI #11 - Demographics (Poverty Levels)

| Poverty Levels                | Total     |
|-------------------------------|-----------|
| Total Population              | 6587600.0 |
| Percent Below: 50% of poverty | 9.5       |
| 100% of poverty               | 17.7      |
| 200% of poverty               | 33.5      |

#### Notes - 2010

##### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

#### Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

##### HSI #12 - Demographics (Poverty Levels)

| Poverty Levels                  | Total     |
|---------------------------------|-----------|
| Children 0 through 19 years old | 1791929.0 |
| Percent Below: 50% of poverty   | 11.2      |

|                 |      |
|-----------------|------|
| 100% of poverty | 21.7 |
| 200% of poverty | 40.8 |

## Notes - 2010

### Narrative:

This indicators reflects raw numbers instead of rates, therefore trends cannot be determined.

## F. Other Program Activities

### Bright Futures (BF)

In 2006, OMCH completed work to implement BF as a best practice for child and adolescent health care. OMCH contracted with the University of Washington to provide statewide awareness activities; received additional federal funding to promote the use of BF in Head Start, preschools, and child care settings; and worked with the national Family Voices organization to implement Family Matters: Using BF to Promote Health and Wellness for Children with Disabilities. We are a pilot site for this 3-year CDC grant.

### EPSDT

The Department of Social and Health Services, Health and Recovery Services Administration (DSHS-HRSA) developed a series of charting inserts for providers to use in documenting EPSDT exams. The inserts improve documentation and completion of EPSDT exams. This need was identified through the yearly review of MAA Healthy Options Plans. OMCH helped develop the inserts and choose sites to pilot them. Standardized provider chart inserts enabled CHILD Profile to create a Health and Development card for parents to use in keeping track of EPSDT/Well-Child Checkup information. This card is inserted in over 125,000 CHILD Profile mailings per year.

In September 2006, OMCH hosted a State Leadership Workshop for Improving EPSDT, sponsored by MCHB.

### /2009/Prenatal Care Outreach Project for African American Women

Maternal and Infant Health (MIH) contracts with the Tacoma-Pierce County Health Department (TPCHD) for outreach to First Steps eligible pregnant women and women of child bearing age, with an emphasis on reaching African American women. We are exploring ways to enhance outreach that are culturally competent for the African American community.

### Maternal and Infant Disparities: Strategy Development

MIH is engaging disparity affected communities and incorporating their feedback in intervention plans. We are developing relationships with leaders in tribal, urban Indian, African American, low income, and other communities. MIH will report on strategies to reduce disparities in the fall of 2008.//2009//

### SIDS Reduction Project with African Americans Project

MIH contracts with TPCHD to promote risk reduction for SIDS in the African American Medicaid community. TPCHD will provide outreach and education to First Steps providers and clients, child care, churches, and African American leaders and community members.

### First Steps Redesign Project

DSHS-HRSA and DOH worked with providers to redesign the First Steps Program effective October 1, 2003. The revisions were in response to budget concerns and a review of the service delivery model. It improves quality of services; contains expenditure growth; and ties intensity of services to client need. The revision includes Core Services such as client screening, basic health messages, basic referrals/linkages, and minimum level of intervention for identified risk factors.

#### Drug-Endangered Children

OMCH works with a local coalition on ways to provide legal protection for drug-endangered children.

#### Living Room Forums

Genetic Services (GSS) conducted 15 informal forums with members of the public to gather qualitative data and opinions about: newborn screening, equity of genetic services, and genetic discrimination. GSS completed an analysis of the data in August 2005. GSS is using the results to inform the State Genetics Plan and to write and publish a peer-reviewed article.

#### Prenatal Care Collaboration

In 2003, MIH, and the Tobacco Prevention and Control Program, conducted focus groups and key informant interviews with obstetrics providers to determine effective strategies to influence and improve screening and intervention for prenatal substance abuse (including tobacco) and violence. 36 providers participated. MIH uses this information to help guide strategies to disseminate best practice issues to obstetrics providers. See MCH Journal 2007; Volume 11(3), 241-247.

#### Action Plan for Oral Health and Children with Special Health Care Needs (CSHCN)

The Oral Health Program (OHP) received funds to develop a state action plan for oral health for CSHCN. OHP and the CSHCN section hosted a forum with key stakeholders to develop the plan.

/2009/In 2007, OHP received a federal TOHSS grant to improve access to oral health services for CSHCN with minor to moderate chronic conditions and eligible for Medicaid and State Children's Health Insurance Program. The funding will be used to implement a part of the Action Plan for Oral Health and CSHCN.//2009//

#### Child Development Charts

IPCP received funding from three private foundations to support development, revision, and increased dissemination of three child development charts. The charts address five areas of the Washington State Early Learning and Development Benchmarks. This partnership expanded distribution of the development charts to child care, preschool, and health care providers. Charts were distributed to approximately 20,000 health and child care providers and are mailed to about 240,000 parents per year. They are also available to the public through an online ordering system.

***/2010/Three child development charts are now mailed to 253,429 parents per year.***

#### ***Project LAUNCH***

***DOH was awarded a federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant to promote young child (0 to 8) wellness at a local and a state systems level. DOH contracted with one local community to implement evidence-based-***

***practices to strengthen family and caregiver skills to promote positive social emotional development. Evaluation will include local, state, and cross-site measures.***

#### ***WithinReach and the Toll-free Hotline***

***DOH contracts with WithinReach, a private non profit entity. WithinReach operates a Family Health Hotline and an interactive website to connect families with children to essential resources, including free or low-cost health insurance, food resources, immunizations, breastfeeding support, family planning services, parenting support, child development screening services, and many other social and health programs. The program sponsors three statewide health promotion coalitions which promote breastfeeding, childhood immunizations and other health-related issues./2010//***

#### **OMCH Publications**

A variety of publications addressing issues of importance to the MCH population are available in print or via the internet site to public health stakeholders including state and federal agencies, public health professionals and associations, parent and family organizations, and the public.

#### **2005**

- WISE Grant Recommendation Report
- Children & Youth with Special Health Care Needs: Washington State Report -Guidelines for the Development and Training of Community-Based Feeding Teams in Washington
- Guidelines for Sexual Health Information and Disease Prevention

#### **2006**

- MCH Data and Services Report
- Perinatal Indicators Report /2009/updated 2008//2009//
- MCH Data and Services Report ***/2010/Updated chapters on: Adolescent Pregnancy, Child Weight and Physical Activity, Family Violence, Food Insecurity and Hunger, Intentional and Unintentional Injury and Substance Use in Adolescents//2010//***
- Adolescent Needs Assessment
- Children's Mental Health Needs Assessment
- Community Based Nutrition Services for CSHCN in Spokane County, Washington

#### **2007**

- WA State Oral Disease Burden Document.
- Youth With Disabilities: Risk Factors for Injury Data Monograph
- Medical Home Data Monograph and Key Messages
- Care Coordination within a Medical Home -Children's Mental Health Needs Assessment Update
- Healthy Child Care Washington Evaluation Report

#### **2008**

- Starting Point and Guia para Padres con Niños que Necesitan Cuidado Especializado (2008-09)
- Summer Camp Directory
- Child Health Notes (2007-08): Decision Tree: Child with Special Needs Referral Process; Health Supervision for Children in Foster Care; Tube Feedings: Managing the Nutrition Issues; Autism Spectrum Disorders: Early Identification

#### **2009**

- Women's Health and Pregnancy Fact Sheet
- Health of WA State chapters: Adolescent Pregnancy, Unintended Pregnancy, Singleton Low Birth Weight, Infant Mortality, CSHCN, Mental Health, Oral Health, People with Disabilities, Youth Violence, Child Abuse and Neglect, Medical Home, Access to Prenatal and Preconception Care

***/2010/MCH Assessment works with the other OMCH programs as well as external partners***

***and stakeholders to produce data reports, assessments and monographs that provide information useful in planning and operating a broad range of maternal and child health programs. Attached is an annotated list of selected OMCH publications which may be of most benefit for public health stakeholders and policy makers nationwide. Hyperlinks to these resources on DOH's Website are included.//2010//  
An attachment is included in this section.***

## **G. Technical Assistance**

### **1. General Systems Capacity Issues**

#### **a. Cultural Competency**

OMCH wants to provide training at each of four Children with Special Health Care Needs (CSHCN) regional meetings to local health jurisdiction (LHJ) providers on how to interview families of children with special health care needs in a way that is culturally competent. One of the benefits of this training would be to improve the quality of data collected from families by local CSHCN providers to include elements of ethnicity, education, and economic levels so information can be used in program development. We need a trainer who could teach culturally competent interviewing strategies related to children with special health care needs and their families.

#### **b. Integration**

OMCH needs expert facilitation to focus on intra-agency collaboration to improve the health services system for children and families. OMCH/DOH needs to integrate programs within the agency in preparation for cross-agency collaboration. Families often need services from a variety of state programs, agencies and community organizations, but find the services difficult to locate, navigate, and differentiate. OMCH/DOH is collaborating with multiple state and local agencies and organizations on four goals to make the health system work better for families: a common enrollment/application process for easy entry, care coordination to assist families in defining and meeting needs, cross-agency data linkages for program planning, and opportunities for blended funding to maximize impacts.

#### **c. Genetics Education**

There have been many advances in the area of testing for Fragile X and some are advocating for targeted newborn screening. Therefore, an educational conference for genetic service providers is being planned for 2004/2005. Technical assistance funds are being sought to bring a nationally known speaker for this event.

/2008/The Fragile X Forum was held August 28, 2006, and featured keynote speaker Randi Hagerman, MD, Medical Director of UC Davis Medical Institute of Neurodevelopmental Disorders. Parents, genetic counselors, care givers, and local researchers attended and participated in the forum.//2008//

***/2010/Inadequate reimbursement for genetic services can limit access to these services. In June 2009, the Genetic Services Section will convene a forum for private and public payers, and genetic service providers (clinical and laboratory), to discuss billing and reimbursement for genetic services. We are requesting funding assistance to bring in participants from remote locations in Washington State.//2010//***

#### **d. Adolescent Health**

The OMCH needs assistance to collaborate with other state and territorial adolescent health coordinators to improve access to national resources and experts on adolescent health. This will improve program development and expertise at the state and territorial level. The MCHB would

provide support for travel and per diem to attend an annual meeting and funding or assistance in setting up bridge-lines for conference calls between regions.

To ensure that Washington youth are receiving medically and scientifically accurate information OMCH will work with the Washington Office of Superintendent and Public Instruction to develop a list of curricula that are medically and scientifically accurate and have the characteristics of effective sexual health education programs. OMCH requests technical assistance for expert consultation to develop criteria for reviewing sexual health education curricula for medical and scientific accuracy. The Child and Adolescent Health section (CAH) will fund three school-based health centers (SBHCs) in Washington State. CAH will request technical assistance from the National Assembly for School-Based Health Care, Public Health -Seattle & King County, and Oregon Department of Human Services, Public Health Division. These organizations are experts on the development and operation of a SBHC system. Technical assistance will include training to address: best practices, data collection, service delivery methods, and policies.

***/2010/CAH will request funds to conduct a two-day education and training event for 20-30 child care health consultants (CCHCs). CCHCs are located in local health jurisdictions and provide expert guidance to child care providers on improving physical health and safety, growth and development, and social/emotional/behavioral health for young children. The Healthy Child Care Washington program and its partners, over the years, have developed excellent training materials and resources for new and experienced CCHCs, in congruence with national standards. Opportunities for intensive training have been limited by funding and time. About one-third of the CCHC cohort is new since the last time formal trainings were conducted. Funds will be used to help local CCHCs attend the training, and to bring prominent speakers in the state to the conference.//2010//***

#### e. Maternal and Infant Health

Preconception health care can improve birth outcomes by promoting and improving the health of a woman prior to pregnancy. Preconception health care consists of comprehensive screening, health education and promotion and interventions that reduce medical, behavioral, and social risk factors that may affect the health of the woman and future pregnancy outcomes. In order for OMCH to determine effective strategies to increase preconception health services and promote healthier lifestyles, we must collect data from providers practicing in WA State and women 18-30 living in Washington. OMCH needs assessment expertise to design qualitative research tools to conduct qualitative data collection related to preconception health attitudes, behaviors, and services. This data will be used to plan appropriate preconception health activities.

/2009/We no longer plan to submit this request for assessment expertise to design qualitative research tools.//2009//

#### f. Oral Health

The Oral Health Program needs to convene a group of local oral health experts to develop a new funding formula for the distribution of funds to support oral health activities in local health jurisdictions. A collaborative approach to developing a funding formula is recommended by the Public Health Improvement Partnership (PHIP) Funding Allocation Review Process and Allocation Principles. TA funds supporting travel and per diem expenses for workgroup members who to attend meetings will help achieve a true collaborative experience.

/2009/TA funds were used to support travel and per diem expenses for workgroup members who traveled to attend meetings. The workgroup plans to propose the new funding formula in May 2008. The new funding formula will be implemented for 2009-2010 biennium.//2009//

***/2010/The Oral Health Program needs to organize, train and implement the Oral Health Smile Survey. This survey consists of a dental screening for children in Head Start and***

***elementary schools in Washington State. Data from the survey of children's oral health will drive program planning at the state and local level to improve the oral health of children.//2010//***

/2009/g. Public Health Nursing

The CSHCN section has been working with local CSHCN Coordinators to develop a logic model to measure the impact of care coordination through public health nursing on children with special needs and their families. The CSHCN section is seeking funding to support a statewide conference for local CSHCN Coordinators to finalize the logic model and develop a uniform set of measures and outcomes to be used statewide. Data gathered would be used at the local and state levels to ensure ongoing public health support for this population. Additional topics of interest would include grief and loss, self-care, and personal wellness.//2009//

***/2010/h. Local Health Jurisdictions (LHJs)***

***OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. The LHJ Activity Plan and Statement of Work are the mechanisms we use to describe local options for using these funds, track which activities each LHJ is performing, and collect data on them. They also form the basis for billing.***

***The LHJ Activity Plan and Statement of Work were last revised prior to 2001. OMCH needs to update the LHJ Activity Plan and Statement of Work to align with OMCH priorities and performance measures, reduce duplication of effort, and increase the relevance of data collected.***

***We will request assistance to convene a workgroup consisting of OMCH staff and representatives from LHJs. This workgroup would work collaboratively to revise these documents and the systems around them. The result will be a stronger, more efficient partnership for delivering MCH programs statewide.//2010//***

2. State Performance Measure Issues

3. National Performance Measure Issues

a. Medical Homes for Children with Special Health Care Needs

This request relates to NPM03. The CSHCN section requests a national expert to present on Medical Home Spread at the spring 2007 Medical Home Leadership Network (MHLN) Meeting. At least 50 individuals from the MHLN Teams throughout the state will attend to include primary care providers, parents, CSHCN Coordinators and Family Resources Coordinators. Planning for this meeting will include input from the Title V CSHCN Program, Washington Chapter of AAP, and MHLN representatives.

/2009/We no longer plan to submit this request.//2009//

b. This request relates to NPM03.

The CSHCN section requests funding to support participation at a one day Expert Meeting to be held on October 26, 2007, in Seattle. The purpose of the meeting is to identify best practice approaches to providing a Medical Home that can be used to improve the quality of pediatric health care and to define the changes and measures the medical practices that enroll in a statewide learning collaborative will use. Team enrollment begins in December of 2007 with the first learning session planned for May 2008. Funding is needed to support the travel and honorariums for five key participants for the Expert Meeting in October.

/2009/We no longer plan to submit this request.//2009//

c. Family-Professional Partnerships

This request relates to NPM02. Family members, including those representing culturally diverse communities, must have a meaningful and consistent role in systems development at the state and community levels. To do this, diverse families must be able to partner in decision-making at all levels. CSHCN requests a national expert to help in the planning of a Fall of 2007 training with the Washington Family to Family Network (WFFN), including Parent to Parent, Fathers Network, Family Voices, Title V CSHCN Program and other system partners to develop a process for increasing and measuring the number and effectiveness of culturally competent family-professional partnerships in WA. At least 50 families, youth, and professionals will participate.

/2009/We no longer plan to submit this request.//2009//

d. Adolescent Health Transition

This request relates to NPM06. Adolescents with special health care needs face many barriers as they transition to adult health care, including lack of adult providers able to accept them as patients and fear of leaving the security provided by their pediatric practitioners. The CSHCN Program requests a national expert on adolescent health transition issues to provide consultation to the Adolescent Health Transition Project Special Interest Group to assist in identifying and addressing barriers that hinder youth as they transition to adult health care. Strategies and tools for a successful transition would be the focus of the consultation.

e. Immunization Rates

IPCP may request funding to bring in an immunization expert to provide training on increasing immunization rates and addressing parent immunization hesitancy and funding to support local partners in attending the training.

f. Child Death Review Teams

This request related to NPM10 (Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes) and NPM16 (Rate of suicide deaths among youths aged 15 to 19 years). OMCH will request funds to provide 1.5-2 days of training to 15-19 local Child Death Review Teams (CDR) on topics and issues of interest to the teams. The teams previously identified statewide training as a priority. Local CDR Teams provide surveillance and collect data from child death reviews that allow them to make recommendations on how these deaths could be prevented. The data and recommendations are used to generate reports to county commissioners, boards of health and community groups that help inform strategies to reduce by motor vehicle crashes and suicide. Developing skills in being able to interpret data, develop strategies, and engage the community in prevention activities will help teams be more effective in promoting strategies to address intentional and non-intentional injuries.

***/2010/TA funds were used to support staff training in 2007 and a State CDR Conference in 2009. The funds supported registration, meeting space, and CDR team member travel. Many CDR team members would not have been able to participate in these conferences without funding for travel. The 2007 training focused on the transition to use of the national CDR data system. Presentations at the 2009 conference included: Teri Covington, National Center for Child Death Review; Medical Examiner - Doll Reenactment in Infant Death Investigation; Multidisciplinary Panel - How CDR benefits your organization; DOH staff -- Emerging Data Issues; and Harborview Injury and Violence Prevention Center -- Best Practices for CDR Teams and Prevention Recommendations.***

***OMCH plans to request funding for a 2010 CDR Conference.//2010//***

#### /2009/g. Family Leadership Development

Family leadership development is an ongoing focus of the CSHCN section and is a primary responsibility of the section's Family Integration Consultant. The section will request funds to provide 2-day Effective Presentations trainings for an additional 50 parents in the state. The trainings would be a combination of an initial training and a follow-up mentoring.//2009//

#### 4. Data Related Issues

##### a. Western Regional MCH Epidemiology Conference

The annual MCH Epidemiology conference is always held in the Southeast US (e.g. Florida or Georgia). MCH epidemiology staff from the Western US, particularly the Northwest, have a difficult time traveling that far. Maintaining skills in needs assessment and in MCH epidemiology is difficult under these conditions. OMCH requests that MCHB fund and promote a western regional MCH epidemiology conference.

#### /2009/b. Qualitative Assessment and Analysis

OMCH plans to request funding for training and technical assistance to family organizations to increase those organizations' capacity to survey and assess quality of life issues their organizations work to improve. For example, staff from Fathers Network wish to develop a valid survey tool to measure the impact on the relationships with partners and children of men who are regular participants in local and/or state Fathers Network activities.

##### c. Qualitative Research Methods

OMCH needs to build capacity and expertise in qualitative research methods and analysis especially as we begin planning for the 2010 Needs Assessment. Over the past few years, the OMCH Assessment section has increasingly been asked to use qualitative methods and provide technical assistance on the use of qualitative methods to complement quantitative methods in planning program evaluations and program-specific needs assessments. Most of the staff in OMCH Assessment have expertise solely in quantitative methods, so we are requesting TA funds to build internal capacity related to designing and conducting focus groups and analyzing qualitative data.//2009//

## **V. Budget Narrative**

### **A. Expenditures**

The state of Washington uses the Agency Financial Reporting System (AFRS) as its accounting system. Throughout the reporting year, direct program expenditure data are entered and tracked by the OMCH Budget and Contracts Manager as well as program managers and fiscal coordinators. Aggregated data from this report are adjusted to add overhead costs, which have been entered through the agency allocation system (submitted to and approved by DHHS, Region X). The data from both these sources form the basis for the total expenditure data for the year.

The total expenditure data are entered onto spreadsheets by program. These data are apportioned across reporting forms three, four, and five according to percentages determined by program managers, staff, and local health jurisdictions (LHJs). Expenditure data are then apportioned to the 30 percent-30 percent requirements, and the 10 percent administration requirement. The same expenditure data are also apportioned according to percentages designated for populations served (Form 4) and levels of the pyramid (Form 5). In this way, OMCH is able to demonstrate relationships among expenditures and requirements, populations served, and levels of the pyramid.

The results of the above calculations are entered on additional spreadsheets, which contain historical data. From these latter spreadsheets come the variances. Significant variances are analyzed and accounted for. The information is used in building the budget for the coming federal fiscal year (FFY).

/2007/It should be noted that FFY 2005 represents a transitional year for a change in funding characterization that occurred in FFY 2004 and was implemented for budget preparation for FFY 2006. Significant variances resulted from assumptions regarding the availability of Health Service Account (HSA) expenditures to use for MCH Block Grant (MCHBG) match and applied to the total program effort.

Washington State will continue to experience significant variations between budgeted and expended amounts. In the past few years, two events occurred, which affected the variances:

- Significant funding cuts and resource re-allocation occurred.

- Re-characterization of funds in source categories made it difficult to compare across years of budgeted versus expended.

Significant funding cuts and resource re-allocation:

The replacement in 2002 of General Fund-State with Health Service Account funds for Immunizations meant that OMCH could not budget to over-match although it would continue to report total expended effort in its annual reports.

Concurrently, LHJs experienced decreased funding. To help LHJs protect service levels to the MCH population, OMCH permitted state funds to be used at the local level to achieve Medicaid (Title XIX) match. The result was that OMCH had less state dollars to use for Title V MCHBG Maintenance of Effort and thus needed to rely more on Health Services Account dollars for match.

Re-characterization of funds in source categories make it difficult to compare across years of budgeted versus expended:

The primary issue then became how to characterize the different sources of expenditure in

discrete categories that made sense over time.

In 2002, Health Service Account fund expenditures were separated from General Fund-State match expenditures by categorizing the former as Other Funds on Form 2. This created confusion on how to report State funds that were expended as part of Medicaid (Title XIX) match.

By FFY 2003, Health Service Account funds were budgeted on Form 2, line 3, State Funds along with General Fund-State to indicate the MCHBG match.

Continued fiscal reductions meant that the FFY 2004 budget was for Maintenance of Effort only. With the FFY 2004 reporting, OMCH experienced the impact of LHJs using state funds for Medicaid match. OMCH received clarification from MCHB that state funds for Medicaid could be budgeted and tracked on line 5, Other Funds to cleanly report the total expenditure effort for OMCH. Therefore, OMCH determined that General Fund-State funds and Health Service Account funds would be budgeted and reported on Form 2, line 3 State Funds; that local and solicited funds would be reported on line 4, Local Funds; and that State funds for Medicaid would be budgeted and tracked on line 5, Other Funds. The budget for FFY 2006 reflects these distinctions as does the Annual Report for FFY 2005.

By FFY 2007 the fund sources will cleanly match to the expenditure sources. However, OMCH will continue to experience significant budgeted versus expended variations until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

/2008/In FFY 2006, the impacts of decreased funding were evident in the spread of expenditures throughout the MCH pyramid categories. The most dramatic was that OMCH spent 81% less than was budgeted for Direct Services. This change signals a further shift away from direct service in the face of reduced funds. Activities focused on Enabling, Population Based, and Infrastructure Building. Other federal funding is a significant part of OMCH's ability to address the needs of the MCH population. In FFY 2006, OMCH experienced a \$400,000 decrease in SPRANS Bright Futures expenditures and a \$700,000 decrease in CDC expenditures for the Immunization/CHILD Profile program. These reductions were offset by a \$200,000 increase in Title XIX federal funding participation and OMCH achieved this by directing more state dollars to leverage the funds. This strategy will be lessened in FFY 2008.//2008//

/2009/As in previous years, any activities involving vaccines increased the variance of budgeted to expended amounts. Health Service Account funds are limited to achieving the Maintenance of Effort for budget projections. However total actual expenditures are allowable for annual reporting purposes (see prior years' notes).

Overall OMCH expenditures increased by slightly over 1% compared to FFY 2006. While State total expenditures for FFY 2007 increased by about 5%, the increase was due to a 14% increase in HSA expenditures over FFY 2006. A 17% decrease in state matchable fund expenditures occurred because OMCH leveraged more of the state dollars for Medicaid Match, increasing those expenditures by 29% over FFY 2006. Additionally, other federal funding decreased 6%. For FFY 2008, OMCH would expect to see the affect of budget reduction decisions.

Expenditures by type of individuals served revealed OMCH's administrative expenditures increased over FFY 2006 by almost 25%. Programs took advantage of carryforward for the second year of FFY 2006 to cover increased operations costs such as rent, salaries, benefits and inflation. Expenditures for children with special health care needs (CSHCN) increased by 25%, infants by 19% and others by 16%, whereas pregnant women decreased 3% and children 1-22 decreased 5%.

Direct Service expenditures increased by 105% from FFY 2006 to FFY 2007. The primary providers are LHJs and their contract is on a calendar year basis, consequently, the substantial increase can be attributed to timing differences. The annual report reflects the second year of

spending for FFY 2006 and the first year of spending for FFY 2007. A comparison of budgeted amounts for FFY 2006 to FFY 2007 shows that the amount budgeted actually decreased by 29% reflecting the budget reductions. All other expenditures by type of service had small increases or decreases, except infrastructure which increased by 7%. While the other categories showed only slight changes, this is masked by the overall reductions in ability to spend and the timing in which it is realized.//2009//

***/2010/OMCH experienced important fiscal changes in recent years that have continued into FFY 2009. In FFY 2006, the MCH Block grant allocation for Washington was reduced by over \$400,000. During the FFY07, OMCH began to realize the impacts of changes in interpretation to the federal Medicaid Administrative Match rules. OMCH completed a contract with DSHS at the end of the first quarter FFY08. Changes in the federal interpretation of regulations reduced Medicaid Match funding by 33% (app \$1,100,000 in federal expenditures) compared to FFY 2007. To meet this cut, the Office needed to discontinue some of the activities to the maternal and child population. For the activities the office was able to retain required shifting other funding sources to offset the difference.***

***In the 2008 state supplemental budget, OMCH received state funding for miscarriage management, cord blood collection, cord blood banking, state funds to offset loss of Medicaid Match and funds to offset federal cuts to core public health functions.***

***The state legislature has needed to increase the amount of funding to maintain the universal vaccine system each year. In FY2007, the latest increase was due to both the addition of the human papillomavirus vaccine and to increased vaccine costs.***

***However, in the final quarter of FFY 2008, the Washington State Governor enacted emergency hiring freezes as well as freezes on purchase of equipment and out-of-state travel. This freeze was extended by the state legislature and has at times included all expenditures identified above regardless of source of funding. With the shortfall in revenue, significant cuts were made to the Department's budget that affects OMCH. The budget includes eliminating vaccine purchase using state general funds for children not covered by the Federal Vaccines For Children program. Other cuts in state general funds amounted to a 25% decrease in the Office's state general fund budget for the biennium (app \$3.1 million)***

***A new federal multi-year autism grant as well as continuing funding for epilepsy contributed to activities related to CSHCN. Implementation of this grant was delayed due to the freezes identified above.***

***Effort for primary and preventive care, children with special health care needs and administration were 37.9%, 37.7% and 5.3% respectively, reflecting the requirement for 30-30-10 spending.//2010//***

## **B. Budget**

Washington State's biennium runs from July 1 of odd-numbered years through June 30, two years following. The Agency Financial Reporting System (AFRS), which contains past, present, and future time periods, does not allow for data input into a succeeding biennium until the new biennium has commenced.

Previously, DOH policy was to recognize federal grant allotments on the first day of the grant budget period, or upon receipt of the Notice of Grant Award, whichever was later.

For the biennium 03-05, Washington State implemented a new policy. Federal grant allotments were estimated for the whole biennium and entered in AFRS. Allotments were adjusted to reflect

actual awards. This policy will continue through the 05-07 biennium.

The FFY 2006 MCH Block Grant (MCHBG) application reflects the most recent award amount; consequently, FFY 2005 will be used. For FFY 2006, actual expenditure data for FFY 2004 from Forms 3, 4, and 5 has been used in the projections. OMCH adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

/2007/The FFY 2007 MCHBG application reflects the most recent award amount; consequently, FFY 2006 will be used. For FFY 2007, actual expenditure data for FFY 2005 from Forms 3, 4, and 5 has been used in the projections. OMCH adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

For FFY 2007 OMCH has designated the Other category on Form 2 to reflect Title XIX state funding as well as state funds not available for MCHBG match that contribute to the total effort. These funds are not considered in planning for and achieving Title V match/Maintenance of Effort.//2007//

While it is expected that the MCH program will achieve its maintenance of effort amount and 75% match, declining funding sources mean that OMCH does not anticipate being able to overmatch its federal allocation. Washington State's Maintenance of Effort is \$7,573,626. For FFY 2006, match will be achieved using state funding as well as Health Services Account (HSA) funding for the Immunization Program.

/2007/Some General Fund State dollars that were historically used to match MCHBG federal dollars have been made available for match at the local level to help alleviate shortfalls for local health jurisdictions (LHJs). Washington State's Maintenance of Effort is \$7,573,626. For FFY 2007, match will be achieved using state funding (not available for match at the local level or used as match for Title XIX) as well as Health Services Account (HSA) funding for the Immunization Program.//2007//

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. This activity is still in its infancy; therefore, it is impossible to estimate budget amounts at this time. Should this occur in any significant manner, OMCH expects variances when it reports for FFY 2006.

/2007/Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. These funds are categorized in Local MCH Funds. This activity is still in its infancy; therefore, budget amounts may vary significantly from actual expenditures reported. OMCH expects variances when it reports for FFY 2007. By FFY 2007 the fund sources will cleanly match expenditure sources (see Expenditure Narrative). However OMCH will continue to experience significant variations in budgeted versus expended until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

Other federal sources, including Title XIX; a number of HRSA and CDC grants; and Washington State Department of Social and Health Services (DSHS) agreements, complement Washington State's total effort. Additionally HSA dollars and local funds support activities addressing the MCH population.

/2007/OMCH is projecting a decrease of more than 20% in other federal funding for FFY 2007. In no case is the office projecting any increase in these sources. Special Projects of Regional and National Significance (SPRANS) grants are expected to decrease by 42%, accounted for by significantly less funds for Early Childhood Comprehensive Systems as well as Social Services and Income Maintenance Research, the latter being a demonstration grant this is wrapping up. Funding from the Centers for Disease Control for Immunizations is expected to be reduced by over 23%. Finally it is expected that there will be less ability to obtain Medicaid Federal Financial

Participation (Title XIX) by about 16%./2007//

Through contracts providing funding to LHJs, OMCH ensures that the minimum 30%-30% requirement is met. To receive funding the LHJs must submit a plan designating at least 30% to children with special health care needs (CSHCN) and preventive and primary care for children. The plan ties related activities to CSHCN and preventive and primary care for children, populations served and the MCH pyramid. LHJs report their expenditure activity by populations served and levels of the pyramid. At the state level, these data form the basis for allocation of funds across programs. Using actual data from FFY 2004, OMCH projects that 52.43% of its budget will be expended on preventive and primary care for children; and 31.34% will be expended for children with special health care needs. Finally, OMCH is budgeting 6.34% for Title V administrative costs.

/2007/Using actual data from FFY 2005, OMCH projects that 54.95% of its budget will be expended on preventive and primary care for children; and 38.56% will be expended for children with special health care needs. Finally, OMCH is budgeting 5.59% for Title V Administrative costs./2007//

/2008/The FFY 2008 MCHBG application reflects the most recent award amount; consequently, FFY 2007 will be used. For FFY 2008, actual expenditure data from FFY 2006 from Forms 3, 4, and 5 has been used in the projections.

For FFY 2008 OMCH continues to designate the Other category on Form 2 to reflect Title XIX state funding as well as state funds not available for MCHBG match that contribute to the total effort. These funds are not considered in planning for and achieving Title V match/Maintenance of Effort.

Using actual data from FFY 2006, OMCH projects that 41% of its budget will be spent on Preventive and Primary Care for Children and 38% will be expended for Children With Special Health Care Needs. OMCH is budgeting 4% for Title V Administrative costs.

Through a variety of contracts and state level efforts, OMCH ensures that it meets the minimum 30%-30% requirement. Contractors are encouraged to adhere to the same formula. OMCH tracks LHJ and other contractors' activities through performance-based contracts.

While it is expected that the MCH program will achieve its maintenance of effort amount and 75% match, declining funding sources has meant that OMCH does not anticipate being able to overmatch its federal allocation. Some General Fund State dollars, which were historically used to match MCHBG federal dollars, have been made available for match at the local level to help alleviate shortfalls for LHJs. Additionally General Fund State dollars have been used to leverage Title XIX federal financial participation funds. Washington State's Maintenance of Effort is \$7,573,626. For FFY 2008, match will be achieved using state funding (not available for match at the local level or used as match for Title XIX) as well as Health Services Account (HSA) funding for the Immunization Program.

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. These funds are categorized in Local MCH Funds. Budget amounts may vary significantly from actual expenditures reported until funding streams are stable. OMCH expects variances when it reports for FFY 2007. Currently, only Immunizations/CHILD Profile (IPCP) and Child and Adolescent Health (CAH) have used corporate partnerships. IPCP has tackled issues around the extent of involvement in OMCH work and the ethics of funding by businesses. CAH is involved in forming partnerships around school based health clinics. During FFY 2008 OMCH will research this funding resource regarding its potential and how it is used.

Reductions in MCHBG funding and the lack of carry over funds from previous years along with

projected decreases in other federal and state sources such as Title XIX, HRSA, and CDC grants, and DSHS agreements will result in further program and service cuts in Washington. Federal funding reductions include the loss of the Abstinence Education funding effective June 30, 2007.

OMCH is facing a serious deficit due to continued flat funding of MCHBG as well as reductions in the other federal programs. State funding increased only minimally for our new 07-09 biennium. The deficit was further affected by cost of living increases that federal funding must absorb.

Additionally, for 2.5 years OMCH has been in contract negotiations with DSHS and CMS regarding its long-standing interagency agreement. This contract naturally evolved when DOH separated from DSHS almost 20 years ago. Because DSHS and DOH are separate agencies, the work by DOH to support Medicaid's state plan must happen in a contract as part of Medicaid Administrative Match. CMS has developed more concrete guidance for this kind of work, including increased administrative tasks, special timekeeping requirements and more narrowly interpreted definitions of acceptable activities. Consequently, OMCH has the potential to lose as much as 30% of its federal financial participation from Title XIX.

For the past few years, OMCH has been able to weather the decreases in state dollars followed by the current situation through careful planning and use of Title V's carry forward option. This is no longer an option adding further stress.

In response to the above fiscal factors, OMCH initiated internal procedures to produce as much savings as possible. When this strategy was exhausted, the office was forced to engage in budget reductions to contractors. These decisions were made carefully and were driven by MCHBG priorities, state priorities and OMCH priorities. These decisions affected projected funding to direct and enabling services for FFY 2008. //2008//

/2009/OMCH anticipates continued flat funding at the federal level. To that end, budget reductions occurring in FFY 2007 will still be in effect. OMCH received the final award in the first week of July 2008. The award was \$11,000 less than projected. Continued decision-making will also occur regarding how to manage the additional shortfall. For the 09-11 Biennium, OMCH is involved in an exercise to reduce 10% of state funding. The DSHS contract is expected to result in less Medicaid match. OMCH's priorities, NPMs, and SPMs form the basis for decision making to assure that activities continue to support MCHB's focus, especially for CSHCN and Primary and Preventive Care.

Maintenance of collaborations with partners and stakeholders serving the MCH population is paramount. Of the Federal-State Partnership, the funding majority will be incurred in Population-Based services because of the large amount of activity around vaccines. Infrastructure Building was allocated the next greatest amount, followed by Enabling, and Direct Services.

From the SFY 2008 Legislative session, OMCH received state funding for some restoration of core public health activities. OMCH also received funding for vaccines, First Steps, neurodevelopmental centers, maxillofacial activities, miscarriage management, and a Parkinson Disease registry. To protect OMCH's core activities, some of the latter funding may be returned as part of a state reduction exercise. On the other hand, OMCH has identified and is applying for grant funding that would respond to identified needs in the MCH population.

FFY 2009's budget provides 37% MCHBG funding for Primary and Preventive Care, 40% for CSHCN and 4% for Administration.//2009//

***/2010/Beginning in the last quarter of FFY 2008, Washington State's Governor instituted a hiring freeze as well as freezes on equipment purchases and out-of-state travel as a means of offsetting the budget shortfall predicted for the end of the state fiscal year. These measures were enacted into law when the legislature convened in January 2009. The***

***projected shortfall of \$9 billion resulted in substantial cuts for the new biennium beginning July 1, 2009.***

***As OMCH enters FFY 2010, it will have lost 3 FTE's. The legislature decided to eliminate the universal vaccine system. Over the next few months state funding for vaccines will be phased out to conclude by May 1, 2010. The total cut will be \$48.5 million. Washington will continue to use federal funds to purchase vaccine for specific eligible children.***

***Funding for the Cord Blood Pilot Project was not renewed and miscarriage management activities were reduced by \$324,000 per year. State funding of \$192,500 for core public health activities was also cut. Additional cuts of approximately \$900,000 per year to meet the Governor's directed freeze and 1% cut included funding for a media campaign to reduce unintended teen pregnancy, a school based health clinic, and three FTEs. Filling state funded and or federally funded positions will require extended review and approval processes. Contracting protocols have been expanded for additional justification and review at several levels of management. For OMCH contractors, a significant risk for lags in service exists as reduced staffing grapples with the increased workload.***

***In response to June's poor economic forecast, the Governor has announced that there will be additional reductions. OMCH does not know how that will translate to our office at this time.***

***In the face of budget cuts, partners and stakeholders such as LHJs have let us know that they will be significantly reducing or ending some locally funded maternal and child health program activities.***

***In this environment, several multi-year federal funding grants will continue: Oral Health Workforce Development, Project LAUNCH, Autism and Epilepsy. Resources from long-standing funding such as SSDI, PRAMS, ECCS, Children's Oral Health Care Access, CDC Immunizations, EHDDI, and Newborn Screening will support activities to maintain infrastructure, population-based services, enabling and direct services to the MCH population. The Immunizations Program will receive economic stimulus funding and the office will continue to seek new funding opportunities. Finally, partnerships with other state agencies such as the Office of the Superintendent of Public Instruction, Community Trade and Economic Development, Department of Early Learning, Department of Social and Health Services, and Liquor Control Board will be strengthened to provide services, data and accessibility to improve the health of MCH groups.***

***Within these budget parameters, OMCH will deploy block grant resources to maintain core activities using the MCHBG funding's flexibility. To that end FFY 2010 expenditures will be 37.9% for primary and preventive care for children , 37.7% for CSHCN and 5.0% for Administration.//2010//***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.